Policy Specification

Medical Insurance

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POLICY PREAMBLE AND SIGNATURES

This Family policy ("Policy") is entered into contract by and between Solidarity General Takaful BSC (The Company), and the “Policyholder,” as described in the schedule. Company may appoint an Administrator (TPA) to provide certain administrative services on behalf of and at the direction of the Company. These services will be described in the Administration Guide and Member’s Handbook.

Upon acceptance of the Policyholder's application and payment of the required Contributions, this Policy is deemed executed. The Company agrees with the Policyholder to provide Coverage for Health Services as set forth in this Policy, subject to its terms, conditions, exclusions, and limitations. The following documents are made part of this Policy:

1. The Policyholder’s application
2. The Schedule of Benefits

This Policy replaces and supersedes any previous agreements relating to the Coverage of Health Services between the Policyholder and the Company. The terms and conditions of this Policy shall in turn be superseded by those of any subsequent agreements relating to the Coverage of Health Services between the Policyholder and The Company.

This Policy shall become effective at 00:01 midnight Bahrain time on the date specified in the schedule, and will be continued in force by the timely payment of the required Contributions when due, subject to termination of this Policy as provided herein. When the Policy is terminated, as provided for in section 3, this Policy and all Coverage under this Policy will end at 00:00 midnight Bahrain time on the date of termination.

This Coverage may be modified by the attachment of Riders and/or Amendments.

This Policy will be governed by the laws of the **Kingdom of Bahrain.**

POLICY INTRODUCTION

This Policy should be read in its entirety. Many of the provisions of this Policy are interrelated; therefore, partial reading may not provide an accurate understanding of Coverage. This Policy sets forth the rights and obligations of the Policyholder and of all Covered Persons. It is important that all insured parties familiarize themselves with its terms and conditions.

Please read the provisions described in these documents to determine the way in which provisions in this Policy may have been changed.

Many words used in this Policy have special meanings. These words will appear capitalized and are defined in Section 1. Reviewing these definitions will provide a clearer understanding of the Policy Coverage.

Network and Non-Network Benefits

This Policy describes both Benefit levels available under the Policy.

Network Benefits - These Benefits apply when a Covered Person chooses to obtain Health Services from a Network Provider. Network Benefits also include Health Services from a non-Network Provider when such services are (1) Medically Necessary Emergency Health Services or (2) approved by TPA. Section 6 describes the procedures for obtaining Covered Health Services as Network Benefits. Network Benefits generally provide Coverage at a higher level than Non-Network Benefits. The Company is financially responsible for payment of Covered Network Benefits.

Non-Network Benefits - These Benefits apply when a Covered Person decides to obtain Health Services from non-Network Providers. Section 7 describes the procedures for obtaining Coverage of Health Services as Non-Network Benefits. Non-Network Benefits are generally Covered at a lower level than Network Benefits. Non-Network Benefits require the payment of and prior authorization for certain Health Services. In addition, when Covered Persons obtain Health Services from non-Network Providers, Covered Persons must file a claim with the Company to be reimbursed for Eligible Expenses.

The information in Sections 1 through 5 and Sections 9 through 10 applies to both levels of Coverage. Sections 6 and 7 explain the procedures Covered Persons must follow to obtain Coverage for Network Benefits and Non-Network Benefits respectively. Section 8 describes which Health Services are Covered. Unless otherwise specified, the exclusions and limitations of Section 12 apply to both levels of Benefits. Section 13 describes what Co-payment/Aggregate Deductible/Coinsurance/Co-payments are required, if any, and to what extent any limitations apply.

Health Services Covered Under the Policy

In order to ensure that eligible expenses are paid as Network Benefits, Covered Persons must always verify the participation status of a Physician, Hospital or other Provider. From time to time, the participation status of a Provider may change. Covered Persons can verify the participation status by calling TPA. If necessary, TPA can provide assistance in referring Covered Persons to Physicians or other Providers who participate with them in the network.
Only Medically Necessary Health Services are covered under the Policy. The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for an Injury or Sickness does not mean that the procedure or treatment is Covered under the Policy.

Health Services, which are obtained through and Covered by a public health program are not Covered under this Policy.

Only Health Services provided in the geographical regions listed in the Schedule of Benefits, are covered under the Policy, unless prior authorization is obtained from TPA. A complete listing of the countries included in each geographical region is included in Schedule of Benefits.

The Company is responsible for interpreting the Benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its Benefits. The Company may delegate discretionary authority to TPA for the provision of services in regard to the Policy.

Should the Covered Person disagree with the claims decision made by TPA, the decision may be formally appealed. The appeal process is detailed in the Member Handbook.

The Company may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, including claims processing and utilization management services. The identity of the service Providers and the nature of the services provided may be changed from time to time in the Company's sole discretion and without prior notice to or approval by Covered Persons. Covered Persons must cooperate with those persons or entities in the performance of their responsibilities.

The Company reserves the right to change, interpret, modify, withdraw or add Benefits or terminate the Policy upon Policy renewal. No person or entity has any authority to make any verbal changes or Amendments to the Policy.

Identification ("ID") Card

Covered Persons must show their TPA ID cards every time they request health care services, also the provider will ask for their personal identity for verification. If Covered Persons do not show their cards, the Providers have no way of knowing that they are Covered under a Policy issued by the Company, and payment may be required by the Covered Person for Network Benefits.

Throughout this Policy Covered Persons will find statements that encourage them to contact TPA for further information. Whenever there is a question or concern regarding Health Services or any required procedure, TPA should be contacted at the telephone number stated on the Covered Person's ID card.

SECTION 1

DEFINITIONS

This Section defines the terms used throughout this Policy and is not intended to describe Covered or Un-Covered services.

"Accident"
A sudden, unexpected, violent external event causing a severe physical bodily Injury, which is usually visually identifiable, and is documented by a competent authority such as a law enforcement officer or Physician.

"Accident related constructive surgery"
The coverage under this policy would be restricted only for the cases resulting from Accidents incurred during the validity of the policy.

"Active at Work"
An employee who is (1) employed on a full-time basis by the Policyholder and is currently being paid a full-time salary, or (2) is on formal paid or unpaid leave from the Policyholder.

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

"Benefit"
The extent or degree of service Covered Persons are entitled to receive under the terms of this Policy.

"Benefit Plan"
The combination of all Benefits that Covered Persons are entitled to receive under the terms of this policy.

"Claim Form"
A form which must be completed by the attending Physician in order for the Covered Person to obtain Coverage.

"**Co-insurance"**

The percentage of Eligible Expenses in addition to the Deductible, which Covered Persons are required to pay for certain Health Services provided under the Policy. Covered Persons are responsible for the payment of any Co-insurance directly to the Provider of the Health Service at the time of service or when billed by the Provider.

"Confinement" and **"Confined"**
An uninterrupted overnight stay following formal admission to a Hospital.

"Congenital Anomaly"
A physical or chemical defect, disease or malformation etc. which may be either hereditary/familial/genetic or due to an influence occurring during gestation up to birth, and may or may not be obvious at birth.

"Contribution"
The periodic fee required for each Primary Insured and each Enrolled Dependent in accordance with the terms of the Policy.

"Co-payment"
The defined monetary amount, in addition to the Deductible, which Covered Persons are required to pay for certain Health Services provided under the Policy. Covered Persons are responsible for the payment of any Co-payment for Network and Non-Network Benefits directly to the Provider of the Health Service at the time of service or when billed by the Provider. This Co-insurance amount may also be deducted at the times of settlement of any reimbursement claim made by the Covered Persons. Applies Also to Co-payment.

"Coverage" or **"Covered"**
The entitlement by a Covered Person to Health Services provided under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Health Services must be provided (1) when the Policy is in effect; and (2) prior to the date that any of the individual termination conditions of Section 3.1 occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

"Covered Person"
Either the Primary Insured or an Enrolled Dependent, but applies only while Coverage of such person under the Policy is in effect.

"Day Treatment"
Medical treatment which must be provided in the Hospital, but which does not require a Confinement.

"Deductible"
An amount that must be incurred and paid for by the Covered Person before benefits are payable under this Policy. This amount is payable by the Covered Person per each outpatient consultation and this amount is stated in the Schedule of Benefits.

"Dependent"
(1) The Primary Insured's legal spouse or (2) an unmarried Dependent child of the Primary Insured or the Primary Insured's spouse (including a natural child, stepchild, a legally adopted child, or a child placed for adoption). The term "child" also includes a grandchild of either the Primary Insured or the Primary Insured's spouse when legal guardianship has been awarded to the Primary Insured or the Primary Insured's spouse. The principal place of residence of the legal spouse or unmarried Dependent child must be with the Primary Insured unless the Company approves other arrangements. The definition of "Dependent" is subject to the following conditions and limitations:

A. The term "Dependent" shall not include any unmarried Dependent child 18 years of age or older, except as stated in the next paragraph.

B. The term "Dependent" shall include an unmarried Dependent child who is 18 years of age or older, but less than 25 years of age if evidence satisfactory to the Company of the following conditions is furnished upon request:
   1. The child is not regularly employed on a full-time basis;
   2. The child is a Full-time Student; and
   3. The child is primarily dependent upon the Primary Insured for support and maintenance.

The Primary Insured will be required to reimburse the Company for any Health Services provided to their Dependents at a time when the Dependents did not satisfy these conditions.

"Designated Facility"
A Hospital, named by TPA as a Designated Facility, which has entered into an agreement with or on behalf of TPA to render Covered Medically Necessary and Medically Appropriate Health Services for treatment of specified diseases or conditions.

"Domestic"
Relates to the country in which the Policy is issued.

"Durable Medical Equipment"
Medical equipment used externally from the human body which: (1) can withstand repeated use; (2) is not designed to be disposable; (3) is used to serve a medical purpose; (4) is generally not useful to a person in the absence of a Sickness or Injury; and (5) is used outside of the Hospital.

"Coverage Category"
Classifications of employees within an employer group, who are eligible for differing levels of Benefits. These Coverage Categories, if any, are listed in Schedule of Benefits to the policy.

"Effective Date"
The date that Coverage becomes effective, which may be either the Enrollment Date of a Covered Person, or the date on which Coverage renews.

"Eligible Expenses"
Reasonable and Customary Charges for Covered Health Services, incurred while the Policy is in effect.

"Eligible Person"

Person who meets the eligibility requirements specified in both the application as well as in the Policy.

"Emergency"
A serious medical condition or symptom resulting from Injury or Sickness which arises suddenly requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of a Covered Person.

"Emergency Health Services"
The health care services and supplies necessary for the treatment of an Emergency. Emergency Health Services are subject to the conditions and Coinsurance/Co-payments as described in this Policy.

"Enrolled Dependent"
A Dependent who is properly enrolled for Coverage under the Policy.

"Enrollment Date"
The original Effective Date of Coverage for a Covered Person.

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

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

B. The subject of an ongoing clinical trial

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

The Company, in its judgment, may deem an Experimental, Investigational or Unproven Service to be a Covered Health Service for treating a life threatening Sickness or condition if it is determined by the Company that the Experimental, Investigational or Unproven Service at the time of the determination:

A. Is safe with promising efficacy; and

B. Is provided in a clinically controlled research setting

"Full-time Student"
A Dependent child who is 18 years of age or older, and less than 25 years of age, who is enrolled in and attending, full-time, a course of study or training at a recognized university or trade school, and is Dependent upon the Primary Insured for his or her support.
Full-time Student status is determined in accordance with the

"General Exclusions"
The health Benefits and services excluded from Coverage that are listed in Section 12 of this Policy and apply to all Covered Persons.

"Health Services"
The health care services and supplies Covered under the Policy, except to the extent that such health care services and supplies are limited or excluded.

"Hospital"

An institution, operated pursuant to law, which: (1) is primarily engaged in providing Health Services on an Inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a staff of Physicians; (2) has 24 hour skilled nursing services. A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

"Hospitalization Class"
The class of Hospital room and services, indicated on the Covered Health Services in Section 8, to which the Covered Person is entitled.

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

"Inpatient"
Hospital Confinement requiring an overnight stay.

"Inpatient Benefit"
Hospitalization or Day treatment or Observation / Treatment in an Emergency Room / Facility which cannot be carried out on out patient basis.

"International"
Outside of the country in which this policy is issued.

"International Emergency Assistance Provider"

An international organization contracted by the Company to provide emergency assistance and emergency evacuation services, as described in section 10, to a Covered Person requiring Emergency Health Services at a location outrite the home country or usual country of residence of the covered person.

"Maternity Benefit-Inpatient"
Includes charges for a vaginal delivery, a Medically Necessary cesarean section, any complications of pregnancy or delivery, and legal abortion

"Maternity Benefit-Outpatient"

Includes charges for all outpatient pre-natal and post-natal Physician visits, including investigations & treatment.

standards set forth by the educational institution. A person ceases to be a Full-time Student at the end of the calendar month during which the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis.
A person continues to be a Full-time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on the last day of the calendar month in which the person was enrolled and in attendance at the institution on a full-time basis, unless an alternate date is stated in Section 13, "Schedule of Benefits."

"Medically Necessary"
Health care services and supplies which are determined by the Company to be Medically Appropriate, and

A. Necessary to meet the basic health needs of the Covered Person; and

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

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

D. Consistent with the diagnosis of the condition; and

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

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

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

2. Safe with promising efficacy
   a) for treating a life threatening Sickness or condition,
   b) in a clinically controlled research setting

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, Sickness or Mental Illness does not mean that it is a Medically Necessary Covered Health Service as defined in this Policy. The definition of Medically Necessary used in this Policy relates only to Coverage and differs from the way in which a Physician engaged in the practice of medicine may define Medically Necessary.

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

"Network"
when used to describe a Provider of Health Services, means that the Provider has a participation agreement in effect with the Company through another entity, to provide Health Services to Covered Persons. TPA may change the participation status of Providers from time to time.

"Medically Appropriate"
Based on the prevailing standards of medical practice relative to a specific condition as per the guidelines of appropriate official bodies in the Kingdom of Bahrain. Based on the prevailing standards of medical practice relative to a specific condition as per the guidelines of appropriate official bodies in the Kingdom of Bahrain.

"Non-Network Benefits"
Coverage available for Health Services obtained from non-Network Providers.

"Out-of-Hospital Benefits"
Benefits offered under this cover are services as Physician consultation, Prescribed medicines, Physiotherapy & Diagnostic testing including pre-operative investigations which are conducted on an Out-of-Hospital basis without jeopardizing the **insured's** health or which do not require **Hospitalization/Day treatment** or necessitate specialized medical attention and care in a **Hospital** before, during or after the delivery of the service.

"Physician"
Any practitioner of medicine who is duly licensed and qualified under the laws of the country in which treatment is received.

"Policy"
The policy, the application of the Policyholder, any individual Primary Insured applications, Amendments and Riders which constitute the agreement regarding the Benefits, exclusions and other conditions between the Company and the Policyholder.

"Policyholder"
The employer or other defined or otherwise legally constituted group to whom the Policy is issued.

"Policy Charge"
Charges in addition to the Policy Contribution that are payable by the Policyholder.

"Policy Period"
The period of time (typically one year) from the Effective Date of Coverage, to the termination of coverage prior to renewal.

"Pre-Existing Condition"
Any bodily injury or illness or its related condition that is medically existing prior to the enrolment date of the **I**nsured member, whether it is known or not known to him, and necessitates the Covered Person to receive care and treatment.

"Preauthorization for Hospitalization Form"
A form that must be completed by the attending Physician of the Covered Person and approved by the TPA prior to hospitalization.

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“Network Benefits”
Benefits available for Covered Health Services when provided by a Network Provider. Health Services provided by a non-Network Provider are considered Network Benefits when such Health Services are approved in advance by the Company or are Emergency Health Services.

“Non-Emergency Hospitalization”
Any Confinement which is not as a direct result of Emergency Health Services.

"Primary Insured"
An Eligible Person who is properly enrolled for Coverage under the Policy. The Primary Insured is the person (who is not a Dependent) on whose behalf the Policy is issued to the Policyholder.

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

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

"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) for non-Network Providers, the reasonable and customary charge.

The Reasonable and Customary Charge for non-Network Providers must be, in the Company's judgment, representative of the average and prevailing charges in Bahrain.

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

"Repatriation"
In case a Covered Person has passed away the Mortal Remains will be repatriated to country of origin, if stated in the Policy Schedule of benefits.

"Rider"
Any attached description of Health Services Covered under the Policy. Health Services provided by a Rider may be subject to payment of additional Contributions. Riders are effective only when signed by the Company and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

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

“Specific Exclusions”
Non-Covered services or Benefits which are specific to the Covered Person being insured.

“**Territory of Occurrence”**
The country where the claimed expenses are incurred.

“Undeclared Pre-Existing Condition”
Any Pre-Existing Condition known to the Covered Person or Policyholder, which is not declared on the medical questionnaire or Policy application.

“Prescription Drugs”
Pharmaceuticals which can **only** be obtained through a prescription written by a licensed physician.

“Waiting Period”
The period of time starting from the Enrollment Date of the Covered Person during which a specified medical condition or type of treatment shall not be Covered under this Policy. All applicable Waiting Periods are listed in Section 13 on the Schedule of Benefits, and on any exclusion that are specific to the Covered Person applying for Coverage.

SECTION 2

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

2.1 Enrollment
Eligible Persons will be enrolled after their Policyholder sends notification of their eligibility for Coverage to the Company.

In addition, new Primary Insured and new Dependents may be enrolled as described below in Section 2.4, 2.5, and 2.6. Except as set forth in this section, Primary Insured and/or Dependents shall be enrolled after a written authorization of the Company. Dependents may not enroll unless the Primary Insured is also enrolled for Coverage under the Policy.

2.2 Eligibility Conditions
The eligibility conditions stated in the Schedule of Benefits are in addition to those specified in Section 2 of the Policy.

2.3 Effective Date of Coverage
Coverage for Covered Persons is effective as specified in the Policy after Contribution has been paid. In no event Health Services rendered or delivered before the Effective Date of Coverage is covered. Any request by the Policyholder for the enrollment of an Eligible Person must be in accordance with the notification requirements outlined in the Administration Guide.

2.4 Coverage for a Newly Eligible Primary Insured
Coverage for newly eligible Primary Insured shall take effect as specified in the Policy. Coverage is effective under the following conditions:

If the Company is notified within 30 days of the Primary Insured's Eligibility Date and receives any required Contribution and the completed health questionnaire if required and the individual is accepted for Coverage by the Company. If the individual is accepted for Coverage by the Company, written notification of acceptance will be sent to the Policyholder.

2.5 Coverage for New Dependents (Except Newborn Children)
Coverage for a new Dependent acquired by legal adoption, placement for adoption, court or administrative order, or marriage shall take effect on the date of the event under the following conditions:

If the Company is notified within 30 days of the new Dependent's eligibility for Coverage and receives any required Contribution and completed health questionnaire if required and the new Dependent is accepted for Coverage by the Company. If the new Dependent is accepted for Coverage by the Company, written notification of acceptance will be sent to the Policyholder.

2.6 Effective Date of Coverage for Newborn Children
Newborn children will become eligible for Coverage on the date of their birth. Coverage will become effective on the date of eligibility under the following conditions

If the Company is notified within 30 days of the newborn child's birth and receives any required Contribution and completed health questionnaire if required and the newborn child is accepted for Coverage by the Company. If the newborn child is accepted for Coverage by the Company, written notification of acceptance will be sent to the Policyholder.

2.7 Effective Date of Coverage for Confinement
If Covered Persons are Confined on their Effective Date of Coverage and do not have Coverage for that Confinement under a prior Company, Health Services related to the Confinement are Covered as long as: (a) Covered Persons notify the Company of Confinement within 48 hours of the Effective Date, as defined in the Member Handbook, or as soon as is reasonably possible; and (b) Health Services are received in accordance with the terms, conditions, exclusions and limitations of the Policy (c) they occur on the Effective Date of Coverage or later.

If Covered Persons are confined on their Effective Date of Coverage and the Confinement is covered under a prior Company, Health Services for that Confinement are not covered under the Policy. All other Health Services are covered as of the Effective Date.

If Covered Persons confined on the Effective Date have prior Coverage, Health Services for the condition or disability will not be covered under the Policy until Covered Person's prior Coverage is exhausted.

2.8

For any inclusion of member/s during the policy period, pro-rata contribution will be charged subject to a minimum contribution of one month.

SECTION 3

TERMINATION OF COVERAGE

3.1 Conditions for Termination of This Entire Policy
This Policy and all Coverage under this Policy shall automatically terminate on the earliest of the dates specified below:

A. Following the last Contribution due date.

B. On the date specified by the Policyholder, prior to the Termination date by a written notice to the Company, that this Policy shall be terminated.

C. On the date specified by the Company, in written notice to the Policyholder that this Policy shall be terminated, due to the Policyholder's violation of participation and contribution rules.

D. On the date specified by the Company in written notice to the Policyholder that this Policy shall be terminated because the Policyholder provided the Company with false information material to the execution of this Policy or to the provision of Coverage under this Policy. The Company has the right to rescind this Policy back to the Effective Date.

3.2 Payment and Reimbursement upon Termination
Upon any termination of this Policy, the Policyholder shall be and shall remain liable to the Company for the payment of any and all Contributions, which are unpaid at the time of termination, including Contribution for any extension period following the last paid date of Coverage.

3.3 Conditions for Termination of a Covered Person's Coverage under the Policy
Covered Person's Coverage shall automatically terminate on the earliest of the dates specified below:

A. The date the entire Policy is terminated, as specified in the Policy. The Policyholder is responsible for notifying Covered Persons of the termination of the Policy.

B. Following the date Covered Persons cease to be eligible as a Primary Insured or Enrolled Dependent.

C. The date the Primary Insured is retired or pensioned, unless a specific Coverage Category is specified for retired or pensioned persons in the Policyholder's application, and the Primary Insured continues to meet any applicable eligibility requirements. Section 5.11 describes the Primary Insured's right to apply for an individual Policy.

The Company has the right to terminate the Policy for any of the following reasons. When any of the following apply, the Policyholder must provide written notice of termination to the Primary Insured:

The date specified by the Company that all Coverage will terminate due to fraud or misrepresentation or because the Primary Insured knowingly provided the Company with false material information, including, but not limited to, information relating to another person's eligibility for Coverage or status as a Dependent, Pre-Existing Conditions, or hazardous activities. The Company has the right to rescind Coverage back to the Effective Date.

3.4 Payment and Reimbursement upon Termination
Termination of Coverage shall not affect any request for reimbursement of Eligible Expenses for Health Services rendered prior to the date of termination. A Covered Person's request for reimbursement must be furnished as required in Section 9. If the Covered Person is Hospitalized on the termination date of the Coverage, Hospital charges for that continuous period of hospitalization will be paid by TPA, according to the Benefits and limitations of the Policy, for up to 31 days following Policy termination.

3.5 Return of I.D. Cards and Claim Forms upon Termination
Upon Termination of Coverage for any Covered Person, it is the Policyholder's responsibility to ensure that terminating Primary Insured return all I.D. cards and unused Claim Forms to the Company.

3.6 Payment for Health Services Incurred after the Date of Termination
The Policyholder will be responsible for reimbursement to the Company for payment of any Health Services obtained by a Covered Person using their I.D. Card or unused Claim Forms after Coverage termination.

3.7 Termination of insured members from a policy

The termination shall be effective from the date the company receives the duly completed deletion request form and I.D cards. The contribution refund shall be calculated on the uncovered period and will be payable after 60days of the deletion date. Any members who have reported claims during the covered period are not eligible to contribution refunds and in the event the Company credits any refund and claims are reported for treatment within the insured period the company has the right to recover the refunded or credited amount. The contribution of the IEAP benefit of Three & Half Bahraini Dinars (BD 3.5) shall be deducted in full from the contribution refund regardless whether a claim is reported or not.

SECTION 4

CONTRIBUTION RATES

4.1 Contributions
Contributions payable by or on behalf of Covered Persons are specified in Policy Schedule to the Policy entitled "Contributions". All Contributions must be paid using the currency referenced in the Policy schedule.

The Company reserves the right to change the schedule of rates for Contributions as described in Schedule of Benefits.

4.2 Computation of Contribution
Each Contribution shall be calculated based on the number of Primary Insured and Dependents in each Coverage Category the Company shows in its records at the time of calculation, at the Contribution rates then in effect. The Contribution is calculated as described in Policy Schedule. Any imposition of or increase in Contribution tax or other governmental charges relating to or calculated in regard to Contribution shall be automatically added to the Contribution.

4.3 Notification of Coverage Changes
The Policyholder shall notify the Company in writing within 31 days of the Effective Date of enrollments, terminations, or other changes.

4.4 Payment of the Contribution
The Contribution is payable in advance by the Policyholder to the Company as described in Policy Schedule. All Contribution payments shall be accompanied by supporting documentation, which states the names of the Covered Persons for whom payment is made.

The Policyholder shall reimburse the Company for attorney's fees and any other costs related to collecting delinquent Contributions.

4.5 Grace Period
A grace period of 31 days shall be granted for the payment of any Contribution, during which time the Policy shall not be terminated and Contribution will be due.

This Policy shall automatically terminate at the end of the 31-day grace period, if the grace period expires and any Contribution remains unpaid, or if the Company receives written notice of termination from the Policyholder during the grace period.

4.6 Currency
All Contribution paid by the Policyholder will be in the currency specified in the Schedule of Benefits.

4.7 Change in Membership
Company reserves the right to change contribution rates if the number of covered members varies by more than 20%, increase or decrease during the period of the policy.

SECTION 5

GENERAL PROVISIONS

5.1 Entire Policy

The Policy issued to the Policyholder, including the Policyholder's application, any individual Primary Insured applications and Health Questionnaires, Amendments and Riders, and the Member Handbook constitute the entire Policy.

5.2 Administrative Services

The services necessary to administer this Policy and the Coverage provided under it will be provided in accordance with the Company's or its designee's most current standard administrative procedures. If the Policyholder requests that such administrative services be provided in a manner other than in accordance with these standard procedures, and such services are agreed to by the Company and TPA, the Policyholder shall pay for such services or reports at the Company's or its designee's then-current charges for such services or reports.

5.3 Limitation of Action

Policyholders or Covered Persons do not have the right to bring any legal proceeding or action against the Company/TPA without first attempting resolution with them in writing. If legal proceedings or actions against the Company/TPA are not brought within one year of the date the Company/TPA notifies the Policyholder or Covered Persons of its final decision, the right to bring any action against the Company/TPA is forfeited.

5.4 Amendments and Alterations

Any change in Coverage Category, Policy Benefits, Riders and Amendments to the Policy are effective only upon the renewal date specified by the Company/TPA. No change will be made to the Policy unless it is made by an Amendment or a Rider, which is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

5.5 Relationship among Parties

The relationships between the Company and Network Providers and relationships between the Company and TPA, are **solely** contractual relationships between independent contractors. TPA, Network Providers and Policyholders are not either agents or employees of the Company nor is the Company or any employee of the Company an agent or employee of Network Providers.

The relationship between a Provider and any Covered Person is that of Provider and patient. The Provider is solely responsible for services provided to any Covered Person.

The relationship between the Policyholder and Covered Persons is that of employer and employee, dependent on Coverage Category as defined in the Policy. The Policyholder is solely responsible for enrollment and Coverage Category changes (including termination of a Covered Person's Coverage through the Company), for the timely payment of the Contribution to the Company, and for notifying Covered Persons of the terms and conditions and termination of the Policy.

5.6 Records

Policyholders and Covered Persons must furnish to the Company in a timely fashion all information and proofs which it may reasonably require regarding any matters pertaining to the Policy. The Policyholder should notify the Company of any change in address or employment status of any Covered Person within 31 days of the change.

By accepting Coverage under the Policy, Covered Persons authorize and direct any person or institution that has provided services to Covered Persons, to furnish the Company/TPA any and all information and records or copies of records relating to the services provided to Covered Persons. The Company has the right to request this information whenever reasonably required. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Primary Insured's application.

The Company agrees that such information and records will be considered confidential. The Company/TPA has the right to release any and all records concerning health care services, which are necessary to implement and administer the terms of the Policy or for appropriate medical review or quality assessment.

The Company or its Network Providers are permitted to charge Covered Persons reasonable fees to cover costs for completing requested medical abstracts or forms which Covered Persons have requested.

In some cases, the Company will designate other persons or entities to request records or information from or related to Covered Persons and to release those records as necessary. The Company's designees have the same rights to this information as does the Company.

During and after the term of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

5.7 Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Health Services, the Company may reasonably require that a Network Physician acceptable to the Company examine Covered Persons at the Company's expense.

5.8 Clerical Error

Clerical error shall not deprive any individual of Coverage under this Policy or create a right to Benefits. Failure to report the termination of Coverage shall not continue such Coverage beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Contributions shall be made. However, no such adjustment in Contributions or Coverage shall be granted by the Company to the Policyholder for more than 60 days of Coverage prior to the date the Company received notification of such clerical error.

5.9 Conformity with Statutes

Any provision of the Policy which on its Effective Date, is in conflict with the requirements of governmental statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

5.10 Notice

Written notice given by the Company to an authorized representative of the Policyholder is deemed notice to all affected Primary Insured and their Enrolled Dependents in the administration of this Policy, including termination of this Policy. The Policyholder is responsible for giving notice to Covered Persons.

Any notice sent to the Company under this Policy and any notice sent to the Policyholder shall be addressed as described in Schedule of Benefits.

5.11 Policy Status when a Primary Insured is no Longer an Employee

If the relationship between an employee and his/her employer changes due to retirement or termination of employment, the Covered Person has 31 days from the date of this change to apply for individual Coverage. The Company can decline this application for any reason, but if they accept the Covered Person for individual Coverage, no Waiting Periods will be applied to the individual Policy.

5.12 Payment of Stamps and Taxes required by Government Entities

The Policyholder shall be liable for payment of any stamps or taxes required by government entities on the provision of health care Benefits.

SECTION 6

PROCEDURES FOR OBTAINING NETWORK BENEFITS

6.1 Health Services Rendered by Network Providers

Covered Persons are eligible for Coverage for Health Services listed as Network Benefits in Section 8 of this Policy if such Health Services are Medically Necessary and are provided by a Network Physician or other Network Provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Health Services, which are not provided by a Network Physician or other Network Provider, are not Covered as Network Benefits, except in Emergency situations or referral situations authorized in advance by the Company. Enrolling for Coverage under the Policy does not guarantee Health Services by a particular Network Provider on the list of Providers. This list of Network Providers is subject to change. When a Provider on the list no longer has a contract with the Company, Covered Persons must choose among remaining Network Providers in order to obtain Network Benefits.

Coverage for Health Services is subject to payment of the Contribution required for Coverage under the Policy and payment of the Co-payment or Co-insurance specified for any service.

6.2 Verification of Participation Status

Covered Persons are responsible for verifying the participation status of the Physician, Hospital, or other Providers prior to receiving such Health Services. Covered Persons must show their ID cards along with the TPA card every time they request Health Services.

If failure to verify participation status or the failure to show an ID card results in non-compliance with required Company procedures, Coverage of Network Benefits may be denied.

6.3 Prior Approval Does Not Guarantee Benefits

The fact that TPA authorizes services or supplies does not guarantee that all charges will be covered. TPA reserves the right to review each claim if there are questions regarding Medical Necessity. Under these circumstances, Coverage of some health care services and supplies may be denied. Covered Persons will be notified in writing of any subsequent adjustment of Benefits as a result of the claim review.

6.4 Limitations on Selection of Providers

If a Covered Person is receiving Health Services in a harmful or abusive quantity or manner or with harmful frequency, as determined by the TPA/Company and wishes to obtain Network Benefits, he or she may be required to select a single Network Physician and a single Network Hospital (with which the single Network Physician is affiliated) to provide and coordinate all future Health Services.

Failure to make the required selection of a Network Physician and a single Network Hospital within 31 days of written notice of the need to do so shall result in the designation of the required single Network Physician and Network Hospital for the Covered Person at the discretion of the TPA/Company.

In the case of a medical condition which, as determined by the Company, either requires or could benefit from special services, a Covered Person may be required to receive Covered Health Services through a single Network Provider designated by the Company.

Following selection or designation of a single Network Provider, Coverage of Health Services as Network Benefits is contingent

6.5 Referral Health Services Rendered by Non-Network Providers

In the event that specific Health Services cannot be provided by or through a Network Provider, Covered Persons may be eligible for Network Benefits when Medically Necessary Health Services are obtained through non-Network Providers. Health Services obtained through non-Network Providers must be authorized in advance through referral documentation as designated by the Company. All Health Services are subject to the provisions of Section 7 and other limitations and exclusions of the Policy.

6.6 Emergency Health Services by Network Providers

The Company provides Coverage of Eligible Expenses for Medically Necessary Emergency Health Services, subject to the terms, conditions, exclusions, and limitations of the Policy.

Eligible Expenses for Emergency Health Services are the Reasonable and Customary Charges for the Health Services described in Section 8 of this Policy provided during the course of the Emergency. Such Health Services must be Medically Necessary for stabilization and initiation of treatment. The Health Services must be provided by or under the direction of a Physician.

Health Services rendered on an Emergency basis are not covered if, in the opinion of the Company, the situation is later determined to be not an Emergency.

6.7 Emergency Health Services by Non-Network Providers

Covered Persons obtaining Emergency Health Services must notify TPA within 48 hours or as soon as reasonably possible. At the Company's request, they must make available full details of the Emergency Health Services received in order for such Health Services to be covered as Network Benefits.

Coverage for continuation of care after the condition no longer is an Emergency requires coordination by a Network Physician and the prior authorization of TPA. If a Covered Person is hospitalized, TPA may elect to transfer him or her to a Network Hospital as soon as it is Medically Appropriate to do so.

Services rendered by non-Network Providers are not Covered as Network Benefits if Covered Persons choose to remain in a non-Network facility after TPA has notified them of the intent to transfer them to a Network facility. A continued stay in a non-Network facility may be covered as a Non-Network Benefit.

6.8 Second Opinion Policy

Coverage of certain Health Services as Network Benefits may require that Covered Persons consult a second Network Physician prior to the scheduling of the Health Service. The Company will notify them that a particular Health Service is subject to a second opinion Policy and will inform them of the required procedure for obtaining a second opinion.

6.9 Services needing Prior Approval

For services and procedure which require TPA's prior approval please refer to the Member Handbook.

upon all Health Services being provided by or through written referral of the designated facility or Provider.

SECTION 7

PROCEDURES FOR OBTAINING NON-NETWORK BENEFITS

7.1 Non-Network Benefits

Non-Network Benefits apply when a Covered Person decides to obtain Health Services from non-Network Providers. Non-Network Providers may request payment of all charges when services are rendered. A Claim Form must be filed with the Company for reimbursement of Eligible Expenses. If a Co-payment applies to Non-Network Benefits, the amount of the Co-payment will be deducted from the amount reimbursed to the Primary Insured.

7.2 Prior Approval

To obtain maximum Non-Network Benefits prior approval must be obtained for certain Health Services received from non-Network Providers. Health Services, which require prior approval, are referred to Section 6.9. Covered Persons are responsible for assuring that required prior approval is received before services are rendered and a Pre-Hospitalization Form is completed by the attending Physician and approved by TPA prior to hospitalization.

Failure to comply with the prior approval requirement for Non-Network Benefits may result in no Coverage of such Health Services.

7.3 Denial of Health Services without Prior Approval

To confirm that Non-Network Benefits are covered, prior approval must be obtained from TPA for Health Services received from non-Network Providers. For services and procedures which require TPA's prior approval please refer to the Member Handbook.

7.4 Prior Approval Does Not Guarantee Benefits

The fact that TPA authorizes services or supplies does not guarantee that all charges will be covered. TPA reserves the rights to review each claim if there are questions regarding Medical Necessity. Under these circumstances, Coverage of some health care services and supplies may be denied. Covered Persons will be notified in writing of any subsequent adjustment of Benefits as a result of the claim review.

7.5 Limitations on Selection of Providers

If a Covered Person is receiving Health Services from Providers in a harmful or abusive quantity or manner or with harmful frequency, as determined by the Company, he or she may be required to select a single Network Physician and a single Network Hospital (with which the single Network Physician is affiliated) to provide and coordinate all future Health Services. All additional provisions indicated in Section 8.3 shall be applicable.

SECTION 8

COVERED HEALTH SERVICES

Health Services described in this section are Covered when such services are:
A. Medically Necessary (refer to definition in Section 1);
B. Provided by or under the direction of a Physician or other appropriate Provider as specifically described; and
C. Not excluded as described in Section 12, "General Exclusions".

Network Benefits: Are subject to the payment of any Deductible, Co-payment and/or Co-insurance listed in Section 3. Network Benefits include Medically Necessary Emergency Health Services as described in Section 6.

Non-Network Benefits: Are subject to the payment of Co-payment or Co-insurance listed under the "Non-Network Co-insurance" column in Section 13. Covered Health Services must be pre-authorized by TPA when obtained from non-Network Providers. The Co-insurance payment required by the Covered Person for Covered Health Services is stated in Section 13, Schedule of Benefits.

8.1 Medical Services in a Physician's Office
These are Health Services provided by or through a Physician in the Physician's office. A Physician's office may be located in a clinic or Hospital. Covered Health Services exclude preventive medical care such as routine physical examinations, vision and hearing screenings, voluntary family planning, and immunizations.

8.2 Emergency Outpatient Health Services
Health Services for stabilization or initiation of treatment of Emergency conditions provided on an outpatient basis at a Hospital.

8.3 Outpatient Prescription Drugs
Coverage is only provided for prescription drugs prescribed by a licensed Physician. Imported drugs are covered only if the Ministry of Health approves the drug; No Coverage is provided for those pharmaceuticals specifically excluded in Section 12.

8.4 Outpatient Physical Therapy
Short-term physical therapy services. Coverage is provided only for physical therapy prescribed as a result of a Covered Injury or post surgery and expected to result in significant physical improvement in the Covered Person's condition within 2 months of start of treatment. Coverage is limited as stated in Section 13, Schedule of Benefits. Physical therapy must be provided under the direction of a Physician and approved in advance by the Company/TPA.

8.5 Diagnostic Surgical and Therapeutic Services
Health Services for outpatient surgery, laboratory, radiology and other diagnostic tests and therapeutic treatments (such as chemotherapy) provided by or through a Physician. Health Services must be provided at a Hospital.

8.6 Eye Examinations
Eye examinations provided by a Provider in the Provider's office. Refraction examinations to detect vision impairment are limited to one every calendar year. This benefit is covered only if stated in the Schedule of Benefits.

8.7 Day Treatment
Services and supplies provided in a Hospital setting, when there is no overnight Confinement. This Benefit only applies to services, which cannot be provided in an outpatient facility, such as a Physician's office.

8.8 Inpatient Hospital and Related Health Services
Confinement, including room and board, and services and supplies provided during Confinement in a Hospital. Health Services must be provided by or through a Physician and all Non-Emergency Hospitalizations must be authorized in advance by TPA through completion of a Pre-Hospitalization Form at least 72 hours prior to the hospitalization. Certain Health Services rendered during a Covered Person's Confinement are subject to separate Benefit restrictions and/or Deductibles, Co-payment and/or Co-insurance as described elsewhere in this Policy.

8.9 Professional Fees for Surgical and Medical Services
Professional fees for surgical services and other medical care provided by or through a Physician. Health Services must be provided in a Hospital setting.

8.10 Hospitalization Class
The class of hospitalization for which Covered Persons are eligible is defined in Section 13, Schedule of Benefits.

The selection by the Policyholder of Coverage for a specific Hospitalization Class does not guarantee the availability of that accommodation class for an admission into the Hospital. If a Covered Person is admitted into a more expensive Hospitalization Class than has been contracted for by the Policyholder, the Covered Person will be responsible for all charges in excess of those that would have been incurred under the Hospitalization Class indicated in Section 13, Schedule of Benefits.

8.11 Ambulance Services
Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be rendered. Coverage is only provided in the event of an Emergency.

8.12 Transplantation Health Services
Health Services for transplants when ordered by a Network Physician, provided at or arranged by a Designated Facility for transplants and authorized in advance by the Company. Transplantation Health Services must be Medically Necessary, as determined in advance by the Company, and rendered in accordance with the Company's policies for transplantation Health Services. Coverage is provided for kidney, kidney/pancreas, liver, heart, lung, and heart/lung transplants.

Note:- Charges for of carrying out Transplant are covered but the cost for procuring the organ is excluded under the Policy.

8.13 Maternity Services
Maternity-related medical, Hospital and other Covered Health Services are treated as any other Inpatient or outpatient Benefit. Maternity Benefits - Outpatient includes prenatal and postnatal care provided by a Physician in an outpatient setting. Maternity Benefits - Inpatient covers Health Services provided during childbirth or complications of pregnancy. The total amount reimbursable for Inpatient and Outpatient maternity care is indicated in the Schedule of Benefits.

8.14 Repatriation
In case an Insured member has passed away Mortal Remains will be repatriated to country of origin. The Company shall be liable up to the maximum sub limit specified in the Schedule of Benefits.

SECTION 9

REIMBURSEMENT

9.1 Reimbursement of Eligible Expenses from Network Providers

Network Providers are responsible for submitting a request for payment of Eligible Expenses directly to TPA. In the event a Network Provider charges any fees other than Co-payments or Co-insurance, the Covered Person should contact TPA.

The Company is not responsible for payment of any rendered services, which are not covered under the provisions of this contract. The Policyholder will be responsible for collecting payment from the Primary Insured and for reimbursement to the Company, of any charges incurred by the Covered Person, which are not covered under the provisions of this contract, and have been paid by the Company to the Provider on behalf of the Covered Person.

9.2 Reimbursement of Eligible Expenses from Non-Network Providers

The Company shall reimburse Covered Persons for Eligible Expenses incurred with non-Network Providers on the same basis as a Network Provider, only for EMERGENCY HEALTH SERVICES OR SERVICES AUTHORIZED OR APPROVED BY TPA in accordance with the terms of the Policy. The Company shall reimburse Covered Persons for all other Eligible Expenses from Non-Network Providers, subject to the terms, conditions, exclusions and limitations of the Policy, including Reasonable and Customary limitations.

In order to obtain Coverage for outpatient Health Services from a Non-Network Provider, the Covered Person must submit all original required documents (as delineated in the Reimbursement Form) within 30 days of date of service if service rendered within Bahrain and 60 days if service was rendered outside of Bahrain; the Company shall reimburse in accordance with the plan chosen after applying the applicable deductible and/or co-payment.

The Company is not responsible for payment for any services provided that are not covered under the provisions of this contract.

9.3 Filing Claims for Reimbursement of Eligible Expenses from Non-Network Providers

The Primary Insured is responsible for sending a request for reimbursement to the Company's office. Any outpatient claim must be submitted in original along with all related test results, itemized cost & medical report that has been completed by the attending Physician of the Covered Person. Requests for reimbursement should be submitted within 30 days after the date of service. Unless the Primary Insured is legally incapacitated, failure to provide this information to the Company within this timeframe shall cancel Coverage for that service. Reimbursement for Covered Services will be made directly to the Primary Insured.

9.4 Limitation of Action for Reimbursement

Policyholders or Covered Members do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 90 days after a request for reimbursement has been submitted, as described above, and all steps in the appeal process described in the Policy Introduction have been followed. If such legal proceeding or action has not been brought within one (1) year of the date the request for reimbursement is denied, all rights are forfeited to bring any action against the Company.

SECTION 10

INTERNATIONAL EMERGENCY ASSISTANCE

MEDICAL ASSISTANCE

10.1 Evacuation and repatriation

a) The International Emergency Provider (IEAP) will arrange and IEAP Underwriters will pay for such necessary expense of air and/or surface transportation, medical care during transportation, communications and all usual and customary ancillary services incurred in moving and transporting a Covered Person to the nearest hospital where appropriate medical care is available, which may be a location other than the Covered Person Home Country or Usual Country of Residence.

b) IEAP will arrange and IEAP Underwriters will pay for such necessary expenses to transport the Covered Person to his/her Home Country or Usual Country of Residence following a medical evacuation for subsequent in-patient hospitalisation or rehabilitative treatment.

c) IEAP reserves the right, at its sole discretion, to determine whether the Covered Person Medical condition is sufficiently serious to warrant medical evacuation, the location to which the Covered Person will be evacuated and the means or method by which such evacuation or repatriation will be carried out. In making such arrangements, IEAP may consider all relevant circumstances including, but not limited to the Covered Person medical condition, the degree of urgency, the Covered Person fitness to travel, airport availability, weather conditions and travel distance in determining whether transportation will be provided by private medically equipped aircraft, helicopter, regular scheduled flight, rail or land vehicle. Transportation shall be carried out under constant medical supervision, unless otherwise approved by an IEAP physician.

10.2 Companion ticket

Following a Covered Person medical evacuation and with IEAP' prior written approval, IEAP will arrange and IEAP Underwriters will pay for the cost of one economy class round trip airfare for a relative or friend to join a Covered Person who has or will be hospitalised outside his/her Home Country or Usual Country of Residence for more than seven (7) days. IEAP shall not be responsible for the companion's accommodation costs.

10.3 Repatriation of mortal remains

In the event of the Covered Person death and with IEAP' prior written approval, IEAP will arrange and IEAP Underwriters will pay for all reasonable and necessary expenses, for transporting the Covered Person mortal remains from the place of death to the Covered Person Home Country or Usual Country of Residence or, if requested by a family member or legal representative and with IEAP prior written approval, IEAP will arrange and IEAP Underwriters will pay for the reasonable and necessary expenses for a local burial at the place of death, but such expenses are not to exceed the cost to repatriate the Covered Person mortal remains from the place of death to the Covered Person Home Country.

10.4 Compassionate visit

Upon request from the Covered Person, IEAP will arrange and IEAP Underwriters will pay for one economy class return airfare for a relative or a friend of the Covered Person to join the Covered Person who, when travelling alone, is hospitalised outside the Home Country or Usual Country of Residence for a period in excess of seven (7) consecutive days, subject to IEAP' prior approval and only when judged necessary by IEAP on medical and compassionate grounds.

10.5 Transportation of minor children

If a Covered Person has minor children who are left unattended as a result of a Covered Person injury, illness or medical evacuation, IEAP will arrange and IEAP Underwriters will pay for the cost of economy class one way airfares for the transportation of such minor children to the Covered Person Home Country or Usual Country of Residence. IEAP will arrange and IEAP Underwriters will pay for an escort, whenever necessary.

10.6 Convalescence expenses

Upon request from the Covered Person, IEAP will arrange and IEAP Underwriters will pay for the additional hotel accommodation expenses necessarily and unavoidably incurred by the Covered Person related to an incident requiring emergency medical evacuation, emergency medical repatriation or hospitalisation. IEAP' prior approval, subject to its determination on medical grounds, is required in respect of such payment.

10.7 Medical expense guarantee, cost review & payment, medical monitoring

IEAP will, when authorised by the Company, guarantee and pay as an agent for the Company all costs associated with a Covered Person inpatient or outpatient medical care, and will monitor and provide the Authorised Person with medical evaluations of the Covered Person condition and ongoing medical expenses when hospitalised.

10.8 Dispatch of medication & medical supplies

IEAP will, when and where practical and legally permissible, arrange for delivery of medicines, drugs and medical supplies that are medically necessary for a Covered Person care and/or treatment but which are not available at or near the Covered Person location. IEAP will not pay for the costs of such medicine, drugs or medical supplies and any delivery costs thereof. The delivery of such medicines, drugs and medical supplies will be subject to the laws and regulations applicable locally.

10.9 Emergency & routine medical advice

IEAP will arrange for the provision of medical advice over the telephone for any Covered Person calling an IEAP alarm centre.

10.10 Medical & dental referrals

IEAP will provide the Covered Person with names, addresses, telephone numbers and if requested by a Covered Person and if available, operating hours for physicians, hospitals, clinics, dentists and dental clinics (collectively called 'Medical Service Providers') within the area where the Covered Person is located. These recommendations are based upon the best judgment of IEAP and its knowledge of the local conditions and availability of medical services at the geographical location involved. IEAP does not guarantee the quality of the Medical Service Providers nor shall IEAP be liable for any consequences arising out of or caused by the services provided by the Medical Service Providers. The final selection of Medical Service Providers shall be the responsibility of the Covered Person.

10.11 Outpatient case management

IEAP will assist a Covered Person with the arrangement and confirmation of appointments with Medical Service Providers, assistance in arranging accommodation, post appointment communications and follow up with a Covered Person.

SECTION 11

COORDINATION OF BENEFITS, SUBROGATION AND REIMBURSEMENT

11.1 Coordination of Benefits Applicability

This Coordination of Benefits (COB) provision applies when a person has health care Coverage under more than one Coverage plan (including Coverage under a government sponsored health care program). Benefit payment will be coordinated with the other Coverage according to the standard administrative practices of the Company. Under no circumstances will a Covered Person be reimbursed for more than 100% of eligible charges from all insurers. The Covered Person agrees to cooperate with the Company in providing documentation of Benefits paid by other insurers.

11.2 Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company shall be entitled to all rights of recovery for the reasonable value of services and Benefits provided by the Company to any Covered Person, from any third party or entity that either provides or is obligated to provide Benefits or payments to the Covered Person.

The Covered Person agrees to execute and deliver such documents (including a written confirmation of assignment, and consents to release medical records), and provide such help as may be reasonably requested by the Company in exercising this right of Subrogation and obtaining recovery where applicable.

SECTION 12

GENERAL EXCLUSIONS

Exclusions. Except as may be specifically provided in Section 13 or through a Rider to the Policy, the following Treatments including Medical Conditions, Items, Supplies, Procedures and all their related or consequential expenses are excluded from this Policy:

a) Health Services, which are not Medically Necessary.

b) Dental services provided by a Doctor of Dental Surgery, a Doctor of Medical Dentistry, or by a Physician licensed to perform dental services. (Except in cases of accidental injury, where damage has occurred to sound natural teeth. Services are covered for initial pain relief & for any treatment necessary to preserve the dental structure for future permanent restoration for damage done to sound natural teeth.)

c) 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, or treatment for the temporomandibular joint.

d) Custodial care; domiciliary care; private duty nursing; respite care; rest cures. (Custodial care means (1) non-health related services, such as assistance in activities of daily living, or (2) health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing or (3) services which do not require continued administration by trained medical personnel.)

e) Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.

f) Health Services and associated expenses for non-accident related cosmetic and/or reconstructive procedures.

g) Health Services and associated expenses for the surgical treatment and non-surgical, medical treatment of obesity (including morbid obesity), and any other weight control programs, services, or supplies.

h) Health Services and associated expenses for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for Health Services which are otherwise Experimental, Investigational or Unproven that are deemed to be, in the Company's judgment, Covered Health Services. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

i) Health Services that are performed outside of the country in which this contract is issued, unless prior approval is received from the Company, or International Coverage is provided under the related Benefits.

j) Any Health Services and associated expenses for alopecia, baldness, hair falling, dandruff, wigs, or toupees.

k) Services and supplies for smoking cessation programs and the treatment of nicotine addiction are excluded.

l) Non-Medically Necessary amniocentesis. Health Services and associated expenses for sex transformation operations, voluntary sterilization and for reversal of sterilizations. Contraceptive supplies or services. All services related to fertility/infertility such as varicocele or polycystic ovary/ ovarian cyst or hormonal disturbances etc. and sexual dysfunction.

m) Prosthetic Devices and Durable Medical Equipment.

n) Any accident, sickness or injury resulting from Hazardous activities as mentioned below:

1. Any form of aerial flight (including light aircraft, monoplanes, ballooning, hang-gliding, parachuting), other than as a fare paying passenger in s scheduled passenger airline.
2. Participation in any kind of power-vehicle race, rally or competition
3. Water sports (powerboats, water skiing, jet skiing, diving)
4. Horse riding activities (hunting, jumping, polo, racing)
5. Climbing activities (mountaineering, rock-climbing, pot holing, abseiling)
6. Judo, boxing, karate, wrestling and other martial arts of any kind.
7. Bungee jumping
8. Any professional sports activities

o) Growth hormone therapy.

p) Charges incurred in connection with the provision or fitting of hearing aids, eyeglasses or contact lenses. Optometric therapy is excluded.

q) Travel or transportation expenses, even though prescribed by a Physician. (Ambulance services and Repatriation are covered as described in Section 8 and section 10).

r) Health Services for treatment of military service-related illnesses and disabilities, when the Covered Person is legally entitled to other Coverage and facilities are reasonably available to the Covered Person.

s) Mental Health and/or Substance Abuse Services, including pharmaceuticals, in-patient and out-patient treatments.

t) Self-inflicted or voluntary harm or injury including attempted suicide

u) Outpatient prescribed or non-prescribed medical supplies including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-Prescription Drugs and treatments. (Bandages, gauze etc. are covered as a part of emergency treatment given at any medical facility)

v) All preventive cares, including vaccinations, immunizations, allergy testing & desensitization; any physical, psychiatric or psychological examinations or testing during these examinations.

w) Services rendered by a Provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

x) Enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements, unless done as a consequence to other Medically Necessary Inpatient care.

y) Coverage for an otherwise Eligible Person or a Dependent who is on active military duty; Health Services received as a result of terrorism, war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

z) Services and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, or for muscle stimulation by any means (except treatment of fractures and dislocations of the extremities).

aa) Acupuncture; acupressure; hypnotism, Rolfing; massage therapy; aromatherapy; Homeopathic treatments; and other forms of alternative treatment.

bb) Health Services and associated expenses for in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation.

cc) Elective non-**accident** related surgery for correction of refraction errors and/or Improvement of vision (quantitative or qualitative).

dd) Nasal septum deviation; nasal concha resection.

ee) Sexually transmitted diseases (STD) and conditions including syphilis, gonorrhoea, genital virus, Hepatitis B, Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC) and the like, however these syndromes have been acquired or named.

ff) All cases related to Viral Hepatitis & the complication except Hepatitis A.

gg) Birth defects, Congenital diseases &/or Deformities.

hh) All cases resulting from alcoholism use of drugs & hallucinatory substances.

ii) Senile dementia, Alzheimer's disease, Menopause and Osteoporosis

jj) Air ambulance transportation (except as covered under section 10).

kk) All medical costs resulting from a work-related accident or Sickness that is Covered by workers' compensation (or any similar program).

ll) Circumcision and any complications or related expenses.

mm) Injury or illness caused directly or indirectly by:

War, invasion acts of foreign enemies, hostilities or war-like operations (whether war be declared or not), civil war, mutiny, civil commotion assuming the proportions or amounting to a popular rising, military rising or usurped power, insurrection, rebellion, revolution

An act of terrorism means an act, 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 organisation(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Nuclear fission, nuclear fusion or radioactive contamination, chemical or biological warfare

In addition to the **Standard General Exclusions**, the following cases, causes, tests, medicines, consumables, accessories and prostheses & procedures are excluded from coverage under this **Policy**.

All cases requiring non- emergency **In-Hospital** treatment/services, which have not been approved by TPA Call Centre prior to admission.

1) All cases requiring emergency **In-Hospital** treatment/services, which have not been notified to the TPA Call Centre at least 24 hours before discharge.

2) All cases under **Specific Exclusion**(s) and clearly mentioned in the policy.

3) Any test and/or treatment not required by a Medical Physician.

4) Any **In-Hospital** treatment, tests and other procedures, which can be carried out on Out-of-Hospital basis without jeopardizing the **Insured'**s health.

5) Any test or treatment, which is not related to a specific symptom and/or disease.

6) Any Pharmaceutical Products, which are not, considered as specific treatment for a particular disease.

7) All Auditory Accessories, Eyeglasses and lenses.

8) All substances which are not considered as medicines such as but not restricted to mouthwash, toothpaste, lozenges, antiseptics, milk formulas, food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency states).

9) More than one Physician consultations in non-excluded cases in a single day or during free follow up period unless referred by his/her initial treating doctor & the referral if medically justified.

10) Any maternity services during a waiting period of 280 days from the enrolment date of the Covered Person, unless renewal of a policy having Maternity Benefit coverage or covered by a special rider.

nn) Elective non-**accident** related surgery for the correction of auditory Acuteness.

oo) Pre-existing conditions are not covered under the policy in respect of individual policy holders and member of groups comprising less then 26 employees, unless specifically declared and agreed payment of additional contribution, where necessary.

pp) All cases related to Maternity unless covered specifically.

qq) All cases related to 2nd conception within the same policy period.

rr) All types of Cyst, unless infected as per pathology report.

ss) Sleeping Disorders.

SECTION 13

SCHEDULE OF BENEFITS

The Schedule of Benefits (1) outlines the Co-payment and/or Co-insurance that a Covered Person is required to pay for Health Services (2) describes any maximum Benefit that may apply (3) any Waiting Periods that must be satisfied prior to eligibility for Benefits. Health Services Covered under the Policy are described in Section 8, "Covered Health Services."

Network Benefits
Are subject to the payment of any Co-payment and/or Co-insurance listed under the "Network Deductible/Co-payment and/or Co-insurance" column. Network Benefits include Medically Necessary Emergency Health Services and referral Health Services received from non-Network Providers as described in Section 6.

Non-Network Benefits
Are subject to the payment of Co-payment and/or Coinsurance listed under the "Non-Network Co-payment and/or Coinsurance" column and subject to Reasonable and Customary limitations. Covered Health Services must be prior authorized by the Company.

Note:
Not all Health Services may be available as Non-Network Benefits. Non-Network Benefits that are subject to prior approval are mentioned in section 7. Failure to obtain prior approval may require payment by the Primary Insured of all charges for such Health Services.

When Co-payment and/or Co-insurance are charged as a percentage of Eligible Expenses, the amount paid for Health Services from Network Providers is determined as a percentage of the negotiated contract rates between the Company and the Provider rather than as a percentage of the Provider's billed charges. The Company's negotiated rate with the Provider is ordinarily lower than the Provider's billed charges.

SECTION 14

TAKAFUL PRINCIPLES AND CONDITIONS

Takaful Principles and Conditions	مبادئ وشروط التكافل
1) The principles and provisions of the Islamic Sharia shall be applicable to this takaful policy as decided by the Company's Sharia Board.	1) تنطبق مبادئ وأحكام الشريعة الإسلامية على وثيقة التكافل هذه وفقاً لما قررته هيئة الرقابة الشرعية للشركة.
2) A policyholder is considered joint liable with the remaining policyholders for compensating the losses suffered by any policyholder. The company shall compensate the policyholder out of the takaful funds for losses and damages sustained according to the terms and conditions set forth in this policy.	2) يعتبر حامل الوثيقة متكافلاً مع بقية حملة الوثائق لتعويض الخسائر التي تقع على أي منهم. وعلى الشركة تعويض حامل الوثيقة من أموال التكافل عن الأضرار التي تقع عليه طبقاً للشروط والأحكام الواردة في هذه الوثيقة
3) A policyholder shall donate all or part of his contribution to pay for the losses suffered by any of the policyholders as per the cooperative or takaful principles.	3) على حامل الوثيقة التبرع بكل أو بعض القسط لتعويض الخسائر التي تقع على أي من حملة الوثائق طبقاً لأسس التعاون أو التكافل.
4) The Company shall manage the takaful operation for benefit of the policyholders as Wakil and will charge a maximum Wakala fee of 20% on Gross Annual Contribution which will be calculated at the end of the financial year and will share 25% of net profit in Mudaraba for its management of the policyholders' investment portfolio. The Wakala fee percentage will be announced in advance before the beginning of the financial year and will be mentioned in every policy or in renewal notices.	4) تقوم الشركة بإدارة عملية التكافل لصالح حملة الوثائق باعتبارها وكيلاً نظير رسوم وكالة لا تتجاوز 20% من مجموع الأقساط السنوية التي سيتم احتسابها في نهاية السنة المالية وسوف تتقاسم نسبة 25% من صافي الربح في المضاربة على إدارتها للمحفظة الاستثمارية لحملة الوثائق. وسيتم الإعلان عن نسبة رسوم الوكالة مقدماً قبل بداية السنة المالية وسيتم ذكرها في كل وثيقة أو عند إرسال إشعارات التجديد.
5) The Company shall invest policyholders' contributions collectively for the benefit of policyholders on a Mudaraba basis for a fee equal to a percentage of the realized profits calculated at the end of the financial year. This percentage fee will be announced in advance before the beginning of the financial year at the Company's offices and will be mentioned in every policy document or in renewal notices.	5) تستثمر الشركة أقساط التأمين التكافلي لصالح حملة الوثائق على أساس المضاربة الشرعية نظير رسوم تساوي نسبة مئوية من الأرباح المتحققة يتم احتسابها في نهاية السنة المالية. ويعلن عن هذه النسبة مقدماً قبل بداية السنة المالية في مكاتب الشركة وفي كل وثيقة أو عند إرسال إشعارات التجديد.
6) The insurance surplus shall be calculated as follows: a. In case the underwriting result of all the insurance branches together produces a loss then the result of all the branches will be treated as one fund and there will be no distribution of surplus for those branches that make a profit. b. In case the underwriting result of all the insurance branches together produces a profit then this surplus will be distributed to the branches which produce a profit and in proportion to their contribution to the overall surplus.	6) يتم احتساب الفائض التأميني عل النحو التالي: أ) في حال كانت نتائج الاكتتاب لجميع فروع التأمين معاً نتج عنها خسارة في الناتج النهائي فسوف تعتبر جميع نتائج الفروع كمحفظة واحدة ولن يتم توزيع أي فائض على الفروع التي حققت أرباح. ب) في حال كانت نتائج الاكتتاب لجميع فروع التأمين معاً نتج عنها أرباح في الناتج النهائي فسوف يعتبر كل فرع منها وحدة مستقلة ويتم توزيع الفائض على الفروع التي حققت أرباح بالنسبة والتناسب.
7) The Company shall distribute from the underwriting surplus to eligible policyholders as follows: a. A policyholder will not have the right to receive any surplus from co-operative surplus, if he is compensated for damage sustained by him where the compensation is equivalent to or more than the contributions. b. A policyholder will have the right to receive a part of his entitlement to the co-operative surplus or a pro-rated part after deducting the damages sustained if the compensation is less than the contributions.	7) ستقوم الشركة بتوزيع الفائض من الاكتتاب على المستحقين من حملة الوثائق طبقاً للتالي: أ) لن يحق لحامل الوثيقة الحصول على شيء من الفائض التأميني إذا تم تعويضه عن الأضرار التي وقعت عليه وكان التعويض مساوياً للقسط أو زاد عليه. ب) يحق لحامل الوثيقة الحصول على جزء من الفائض التأميني بنسبة القسط أو بنسبة الجزء المتبقي بعد خصم تعويض الأضرار التي وقعت عليه إن كان التعويض أقل من القسط.
8) The Policyholder's financial position shall be deemed as one position in respect of each type of Takaful insurance with the Company.	8) تعتبر الذمة المالية لحامل الوثيقة ذمة واحدة لكل نوع من أنواع التأمين التكافلي.
9) If the policyholder does not collect his share of surplus within a period of 5 years from the end of the financial year during which his policy expires that share of surplus shall be considered as a donation by the policyholder to a reserve takaful fund to protect the Policyholders' equity.	9) يعتبر حامل الوثيقة الذي لا يستلم نصيبه من الفائض التأميني التكافلي خلال خمس سنوات من أنتهاء السنة المالية التي انتهت فيها وثيقته التأمينية متبرعاً به لحساب احتياطي التكافل لحماية حقوق حملة الوثائق.
10) No more than 50% of the surplus shall be deducted as a donation for the Takaful reserve provision to protect the policyholders' equity up to a maximum of the Company's capital. In case of the Company's liquidation, this provision will be used for charity as decided by the Sharia Board after settlement of all the policyholders' right.	10) يتم اقتطاع نسبة لا تتعدى 50% من الفائض التأميني التكافلي على سبيل التبرع لحساب احتياطي التكافل وذلك لغرض حماية حقوق حملة الوثائق إلى أن يبلغ هذا الاحتياطي مقدار رأس مال الشركة. ويؤول هذا الاحتياطي في حالة تصفية الشركة إلى وجوه الخير حسبما تقرره هيئة الرقابة الشرعية بعد سداد جميع حقوق حملة الوثائق.