POLICY HOLDER NAME: **JAPAN BANK FOR INTERNATIONAL**
POLICY NO: **P-100-7102-2019-12**

TOKIO MARINE NICHIDO

GROUP POLICY

SECTION A

PREAMBLE

This document is intended to describe the basic purpose of the Insurance Policy and includes a description of the General Scope of Coverage, a list of General Exclusions, details of the General Terms and Conditions and some Definitions of the most commonly used words or phrases.

The overall purpose of this Insurance Policy is to provide cover to eligible Beneficiaries for reasonable and customary expenses incurred through the Medically Necessary Treatment of Medical Conditions and Bodily Injuries under the terms and conditions of this Insurance Policy as agreed with the Policyholder.

NEXtCARE Claims Management LLC is the appointed administrator providing certain administrative services on behalf of and at the direction of the Insurance Company.

In consideration of the payment or agreement to pay the Premium, and on the basis of the request and statements made by the Policyholder on the initial Application Form(s), and subject to the terms and conditions of this Insurance Policy f and any attachment forming part of it, the Insurer agrees with the Policyholder and guarantees to provide the Benefits and Services and their related expenses incurred by each Beneficiary as set out in this Insurance Policy.

SANCTION LIMITATION AND EXCLUSION CLAUSE

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

Acceptance and use of the Access Card(s) automatically implies acceptance of all the terms, conditions, limitations and exclusions of this Policy.

The Insurer

The Policyholder

Note: Throughout this Insurance Policy, the masculine gender shall be deemed to include the feminine, the singular to include the plural and the plural the singular

SECTION B

GENERAL SCOPE OF COVERAGE

Family of In-Hospital Benefits

1. Basic Benefit

This coverage shall apply in conformity with the Applicable Table of Benefits in the event of Non-Excluded Cases of Medical Conditions or Bodily Injuries requiring Hospitalisation, and/or Day-Hospitalisation and/or Emergency in hospital services.

Prior approval is required for all In-Hospital Benefits. In the case of Emergencies, this is waived, but approval must be sought within 24 hours of admission

The following medical costs incurred while in Hospital are covered by this Benefit:

- Room and board according to the Hospitalisation Class as specified in the Table of Benefits
- Intensive care unit and coronary artery disease treatment
- Surgeon and anaesthesiologist fees
- Hospital services (surgery, theatre, anaesthesia, 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, and scans etc. (only related to the original cause of covered Hospitalisation).
- Various therapies including physiotherapy, chemotherapy, radiation therapy, etc.
- Physician and other specialist hospital consultations related to the original cause of covered Hospitalisation.
- In-Patient Maternity services as specified in the Table of Benefits
- Recipient transplantation service
- Ambulance services, if Medically Necessary
- Companion Room & Board expenses for Beneficiary below 16 years of age
- The cost of accommodation of a person accompanying an in-patient in the same room in
- cases of medical necessity at the recommendation of the treating doctor and after the prior
- approval of the insurance company providing coverage
- Emergency Mental health treatments
- Repatriation costs for the transport of mortal remains to the country of origin shall be covered, as defined in the Table of Benefits, in the event of death of the Beneficiary following hospitalisation for a non-excluded Bodily Injury or Sickness

Family of Out-of-Hospital Benefits

1. Physician Consultations

The coverage hereinafter defined is offered in conjunction with the Table of Benefits:

- Diagnostic Tests
- Pharmaceuticals
- Physiotherapy

In the event of Non-Excluded Cases of Medical Conditions or Bodily Injuries requiring Physician attendance, diagnostic tests and/or pharmaceuticals and/or physiotherapy, this Benefit represents

the indemnifiable consultation fee, as specified in the Schedules. A follow-up consultation within 7 days of the first consultation relating to the same Medical condition by the same physician is free of charge.

2. Diagnostic Tests/Procedures

This coverage shall apply in conformity with the Table of Benefits in the event of Non-Excluded Cases requiring the conduction of Diagnostic Tests not requiring Hospital Confinement, as prescribed by a Physician and approved NEXtCARE as Medically Necessary. Prior approval is required for certain diagnostic tests/procedures. For free access, claims and approval requests will be initiated by the network provider to NEXtCARE.

This coverage includes services such as:

- Cardiovascular procedures, including
  - ECG
  - Cardiovascular stress test
  - ECG monitoring
  - Signal- averaged electrocardiograph (SAECG), excluding the costs of any device
  - Nuclear Scans
  - Angiography

- Medical imaging, including
  - X - Rays.
  - Echocardiography (including Doppler echocardiography)
  - CT Scan
  - MRI

- Laboratory
- Blood tests
- Biopsy

3. Pharmaceuticals

This coverage shall apply in conformity with the Applicable Scope of Coverage (Article 4) and as specified in the Schedule in the event of Non-Excluded Cases requiring pharmaceutical Treatment. Pharmaceutical Treatment comprises all drugs recognised by the UAE Ministry of Health as prescription drugs (allopathic only) and as approved by the NCC as Medically Necessary.

Prior approval is required for certain prescriptions based on nature of medications and cost of the claim. Approval request will be initiated by the network pharmacies to NEXtCARE

4. Physiotherapy

This coverage shall apply as specified in the Table of Benefits. Physiotherapy sessions as prescribed by the attending Physician will be subject to a maximum number of sessions as specified in the Table of Benefits. Approval request will be initiated by the network provider to NEXtCARE

5. Preventive services, vaccines and immunizations

If selected*, this coverage shall apply for elective treatments only as stated in the Table of Benefits

**Coverage is mandatory by DHA*

6. Mental Health / Psychiatric treatments

For DHA & HAAD compliant policies:-
If selected, this coverage shall apply for elective treatments only as stated in the Table of Benefits

For other policies:-
If selected, this coverage shall apply for both elective and emergency treatments as stated in the Table of Benefits

7. Alternative Medicine Treatments

If selected, this coverage shall apply for treatments related to Chiropractic/ Osteopathy/ Homeopathy and Ayurvedic only as stated in the Table of Benefits

8. Minor Procedures

This coverage shall apply for Minor Procedures carried out on an outpatient basis. All Minor Procedures require prior approval of NEXtCARE

Maternity Family of Benefits

If selected*, this coverage shall apply in conformity with the General Terms and Conditions of this insurance policy and as specified in the Table of Benefits, in the event of Non-excluded cases relating to pregnancy and delivery.

**Coverage is mandatory by DHA & HAAD*

Maternity Benefit – In-Hospital

This benefit provides coverage for all Hospitalisation charges for delivery cases and/or any complications including non-delivery maternity-related cases that may arise before, during or after delivery up to the financial limits as specified in Table of Benefits and incurred within the territorial scope of cover.

Maternity Benefit – Out-of-hospital

This benefit is covered up to the financial limit as specified in the Table of Benefits.

This benefit provides coverage for the following Out-of-Hospital services for Pre-natal and Post-natal care:

- Physician Consultation
- Diagnostic Tests
- Pharmaceuticals

SECTION C

GENERAL EXCLUSIONS

This Insurance Policy is intended to provide cover for expenses incurred for Medical Treatment of Medical Conditions or Bodily Injuries which, in the opinion of both the treating physician and the NCC doctor, are Medically Necessary and which are covered under the Terms and Conditions of the Insurance Policy.

Eligible exclusion list is referred to table of benefit attached herewith.

This Insurance Policy does not cover, amongst other things, expenses arising directly or indirectly from the following:

Exclusion for Dubai Health Authority (DHA), Northern Emirates & Outside UAE

1. Healthcare Services which are not medically necessary
2. All expenses relating dental treatment, dental prostheses, and orthodontic treatments except Emergency cases (Elective treatments will be covered only if the "Dental Benefit" is chosen and fully as specified in the table of benefit)
3. Home nursing; private nursing care; care for the sake of travelling.
4. Custodial care including
   A. Non-medical treatment services;
   B. Health-related services which do not seek to improve or which do not result in a change in the medical condition of the patient.
5. Services which do not require continuous administration by specialized medical personnel.
6. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies)
7. All cosmetic healthcare services and services associated with replacement of an existing breast implant. Cosmetic operations which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body and breast reconstruction following a mastectomy for cancer are covered.
8. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
9. Medical services utilized for the sake of research, medically non-approved experiments and investigations and pharmacological weight reduction regimens.
10. Healthcare Services that are not performed by Authorized Healthcare Service Providers.
11. Healthcare services and associated expenses for the treatment of alopecia, baldness, hair falling, dandruff or wigs.
12. Health services and supplies for smoking cessation programs and the treatment of nicotine addiction.
13. Any investigations, tests or procedures carried out with the intention of ruling out any foetal anomaly.
14. Treatment and services for contraception

15. Treatment and services for sex transformation, sterilization or intended to correct a state of sterility or infertility or sexual dysfunction. Sterilization is allowed only if medically indicated and if allowed under the Law.
16. External prosthetic devices and medical equipment.
17. Treatments and services arising as a result of hazardous activities, including but not limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any professional sports activities.
18. Growth hormone therapy.
19. Costs associated with hearing tests, vision corrections, prosthetic devices or hearing and vision aids.
20. Mental Health diseases, both out-patient and in-patient treatments, unless it is an emergency condition. (Elective treatments will be covered only if the "Psychiatric benefit is chosen and fully as specified in the table of benefit)
21. Patient treatment supplies (including for example: elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments, excluding supplies required as a result of Healthcare Services rendered during a Medical Emergency.
22. Allergy testing and desensitization (except testing for allergy towards medications and supplies used in treatment); any physical, psychiatric or psychological examinations or investigations during these examinations.
23. Services rendered by any medical provider who is a relative of the patient for example the Insured person himself or first degree relatives.
24. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during in-patient treatment.
25. Healthcare services for adjustment of spinal subluxation.
26. Healthcare services and treatments by acupuncture; acupressure, hypnotism, massage therapy, aromatherapy, ozone therapy, homeopathic treatments, and all forms of treatment by alternative medicine. (Elective treatments will be covered only if the "Alternative Medicine benefit" is chosen and fully as specified in the table of benefit)
27. All healthcare services & treatments for in-vitro fertilization (IVF), embryo transfer; ovum and sperms transfer.
28. Elective diagnostic services and medical treatment for correction of vision. (Elective treatments will be covered only if the "Optical benefit" is chosen and fully as specified in the table of benefit)
29. Nasal septum deviation and nasal concha resection.
30. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related investigations, treatments or procedures.
31. Healthcare services, investigations and treatments related to viral hepatitis and associated complications, except for the treatment and services related to Hepatitis A.
32. Birth defects, congenital* or hereditary conditions including but not limited to neurological diseases, attention deficit disorder, development delay and learning difficulties
This exclusion is waived for eligible new born children or newly adopted children whose respective date of birth or date of official adoption, falls after the effective date of the initial Policy, only in respect of the following cases which can be corrected by surgery: Hernia, Thyroglossal cyst, Pyloric stenosis,

Urinary reflux, Gastro-esophageal reflux, Epispadias, Hypospadias, Bladder extrophy and extrophy of lower abdomen, Posterior uretheral valves, Megaureter, Hydronephrosis and U-P junction, Diaphragmatic hernia, Esophageal atresia, Omphalocele, Euodenal atresia, Intestinal atresia, Congenital

33. Healthcare services for senile dementia and Alzheimer's disease.
34. Air or terrestrial medical evacuation and unauthorized transportation services.
35. Inpatient treatment received without prior approval from the insurance company including cases of medical emergency which were not notified within 24 hours from the date of admission
36. Any inpatient treatment, investigations or other procedures, which can be carried out on outpatient basis without jeopardizing the insured Person's health
37. Any investigations or health services conducted for non-medical purposes such as investigations related to employment, travel, licensing or insurance purposes.
38. All supplies which are not considered as medical treatments including but not limited to: mouthwash, toothpaste, lozenges, antiseptics, milk formulas, food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions); and all equipment not primarily intended to improve a medical condition or injury, including but not limited to: air conditioners or air purifying systems, arch supports, exercise equipment and sanitary supplies.
39. More than one consultation or follow up with a medical specialist in a single day unless referred by the treating physician.
40. Health services and associated expenses for organ and tissue transplants related to a donor only. This exclusion also applies to follow-up treatments and complications.
41. Any expenses related to immunomodulators and immunotherapy.
42. Any expenses related to the treatment of sleep related disorders.
43. Services and educational programs for handicaps.
44. Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.
45. Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type.
46. Healthcare services for injuries and accidents arising from nuclear or chemical contamination.
47. Injuries resulting from natural disasters, including but not limited to: earthquakes, tornados and any other type of natural disaster.
48. Injuries resulting from criminal acts or resisting authority by the Insured Person.
49. All cases resulting from the use of alcoholic drinks, controlled substances and drugs and hallucinating substances.
50. Any investigation or treatment not prescribed by a doctor.
51. Injuries resulting from attempted suicide or self-inflicted injuries.
52. Diagnosis and treatment services for complications of exempted illnesses.
53. All healthcare services for internationally and/or locally recognized epidemics.
54. Healthcare services for patients suffering from (and related to the diagnosis and treatment of) HIV – AIDS and its complications.

SECTION D

WAITING PERIODS

Waiting period on Chronic and Pre existing conditions will be applicable as mentioned in the Table of Benefits

SECTION E

GENERAL TERMS & CONDITIONS

Article 1: Insurance Policy

The Application Form(s) duly completed by the Policyholder, acting on behalf of himself and/or eventual other Beneficiary (ies), the Preamble, the Definitions, the General Terms and Conditions, the Schedules, the Beneficiary the different options as well as any attachment (not the list of Network Providers) and endorsement to any of the aforementioned shall constitute the entire contract between the Insurer and the Policyholder. Any amendment or addition to this Insurance Policy shall be void, unless it has been made in writing and is signed and sealed by the Insurer. No insurance intermediary has the authority to amend this Insurance Policy or to waive any of its provisions.

Article 2: Insurance Policy Validity

The validity of this Insurance Policy (in regard to each Plan selected) begins from the Effective Date and terminates on the Expiry Date as specified in the Policy Schedule. However, each Beneficiary is covered under this Insurance Policy as from his/her Enrolment date as specified under the Policy Schedule and/or any related Endorsement up to the Expiry Date of this Insurance Policy, or to the Deletion Date of the Beneficiary, whichever is earlier.

Article 3: Application

This Insurance Policy and its related endorsements have been issued by the Insurer on the basis of the Policyholder declarations.

The Insurer reserves the right to reject any Subsequent Application, which is not in conformity with the provisions of this Insurance Policy.

The Insurer also reserves the right to terminate the Insurance Policy should any details of the Application be inaccurate or missing.

Article 4: Applicable Scope of Coverage

4.1 In return for the Premium due by the Policyholder to the Insurer the latter undertakes to cover each Beneficiary under a specific Plan/Program as selected by the Policyholder on the Application Forms and approved by the Insurer.

4.2 For each Plan/Program selected by the Policyholder on behalf of each Beneficiary, related Benefits are clearly referred to by category under the Policy Schedule, and further described under the Table of Benefits

4.3 The applicable Scope of Coverage of a given Benefit included in a selected Plan/Program related to a Beneficiary, encapsulates the liability of the Insurer taking into consideration:

- General Exclusions
- Any special terms (Substandard terms)
- The services covered

- The Policyholder Co-Participation when applicable
- The Policyholder Deductible Excess when applicable
- The limits when applicable
- The Territory of Occurrence
- The Provider(s) used
- The nature of care
- The Hospitalisation Class
- The participation of any Priority Payer or Co-Payer when applicable

4.4 The liability of the Insurer under this Insurance Policy towards the Policyholder related to each Benefit within the Plan/Program is described in the applicable Scope of Coverage Schedule. Any expenditure relating to the Beneficiary's Treatment shall be subject to the determination of the Eligible Claim due by the Insurer to the Policyholder.

Article 5: Priority Payer

In case of any participation in a sick/health fund, such as but not restricted to, social security fund or a primary cover under an Insurance Company as a Priority Payer, this applicable scope of coverage shall be activated in excess of the priority payer's participation or refund, in full accordance with other terms and conditions provided herein. The priority payer specifications if any, and if applicable, are specified under the Policy Schedule.

Article 6: Co-Payer

In case of the participation of a Co-Payer, the applicable Scope of Coverage of this Insurance Policy shall apply on a proportional basis with the Co-Payer when applicable. The Co-Payer participation percentage, if any, is specified in the Partnership Schedule; the Insurer participation percentage being the balance of all the Co-Payers' Co-Participation subject to any other terms and conditions herein provided. This refers to original limit, in the case of co-participation; the co-participation option selected will reduce the original limit.

Article 7: Premiums

The premium is the gross Premium plus any applicable stamps and/or taxes if any. 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 instalment 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 and inform the Policyholder that otherwise this Insurance Policy will be cancelled.

If no payment is made at the expiry of this grace period of 30 days this Insurance Policy will be automatically terminated and the Policyholder will be liable for the amount due until the date of.

During these 30 days grace period, Free Access to the Network on direct billing basis *shall be suspended.* In the event the Premiums payment is effected by the Policyholder within the grace period of 30 days, Free Access to the Network on direct billing basis shall be reinstated and all eligible healthcare expenses incurred during the suspended period shall be processed and reimbursed as per policy terms and conditions as specified in Table of Benefits

The Premium payment is substantiated exclusively and solely by the issue of a relevant receipt from a legally authorised representative of the Insurer.

Article 8: Enrolment

The Policyholder has declared in writing at the date of the initial Application that all Employees are enrolled on a compulsory basis. In virtue of the Policyholder declaration, this Insurance Policy was underwritten and issued by the Insurer. Similarly, the Policyholder should have declared if the Legal Dependants per Category are to be enrolled on a compulsory basis or not.

In accordance with the Policyholder declaration on the initial Application form, it is agreed and understood that all Employees, without exception, are to be included under this Insurance Policy. However, the cover becomes effective for those Employees only who are Active at Work on the effective date or any other later date.

Similarly, all Legal Dependants related to a specific Category, for which the Policyholder has declared that enrolment of Legal Dependants is compulsory, are to be included under this Insurance Policy. However, Legal Dependants relating to a Category for which the Policyholder has not required or declared on the initial Application with the status of compulsory cannot be enrolled under this Insurance Policy.

It is fully agreed and understood that the enrolment rules, as stated under this article, form one of the basics of this Insurance Policy. The non-obedience by the Policyholder to these rules shall give to the Insurer the right to terminate this Insurance Policy immediately without premium refund.

Article 9: Addition

9.1 General Rule:

The Policyholder has the right to require from the Insurer, by completing and signing a subsequent Request Form, accompanied with supporting documents, the addition of new Beneficiaries such as new employees, newly wedded spouse or new born children or newly adopted children of an already enrolled employee on a compulsory basis.

9.2 Enrolment Date:

The Eligibility Date is:

- New Employee - The official date of employment in accordance with the Policyholder house rules
- New spouse - The date of marriage
- New-born child - The date of birth
- Newly adopted child - The date of official adoption

If request for an addition is made within 10 days following the eligibility date of a beneficiary, his/her Enrolment Date will be such eligibility date. Otherwise, the Enrolment Date of a Beneficiary is the date on which the Insurer accepts such addition.

9.3 Underwriting:

The initial Underwriting terms as applied on the Effective Date of this Insurance Policy shall be applied for all eligible additions, which were required within a period not exceeding 10 days from the Eligibility Date. In case an addition is required more than 10 days after the Eligibility Date, the

Insurer reserves the right to proceed with a different Underwriting process which may result in different Underwriting terms than the ones applied on the Effective Date of this Insurance Policy.

9.4 Premium:

The Premium relating to any approved addition shall be calculated on a pro-rata basis (compulsory scheme).

Article 10: Deletion

10.1 General Rules

The Policyholder has the right to require from the Insurer, by completing and signing a subsequent Request Form, the deletion of Beneficiaries such as deceased or terminated employees and their Legal Dependants.

10.2 Supporting Documents:

Submission by the Policyholder of supporting documents, relating to deletion requests, which are satisfactory to the Insurer, is a pre-requisite for deletion validation. Among the documents required are the Card Reference of the particular Beneficiaries.

10.3 Deletion Date:

The Deletion Date of any approved deletion is the day following the date of death or termination of the Employee provided request for deletion is made promptly and Card reference number returned to the Insurer. Otherwise, the Deletion Date is the date on which the Card reference number is returned to the Insurer.

10.4 Liability:

The Policyholder shall be the sole and fully liable party towards the Provider(s) and/or NEXtCARE in relation with any expenses incurred by the deleted Beneficiaries as from the Deletion Date.

To this effect the Policyholder should make sure that the Card reference number of the Beneficiary to be deleted has been withdrawn from the Beneficiary and sent back to the Insurer prior to or on the Deletion Date.

10.5 Premium:

The Premium refund relating to any approved deletion shall be calculated on a pro-rata basis for the period remaining after the Deletion Date. No refund is due as long as the Beneficiary's Card reference number is not returned to the Insurer.

Article 11: Category

The Policyholder has declared in writing at the date of the initial Application, the different Categories of his group of Employees and Legal Dependants in accordance with pre-set criteria.

Each Employee shall be enrolled at the initial Effective Date or at any subsequent Enrolment Date with his/her Legal Dependants under a specific Category in full accordance with his/her criteria.

Article 12: Amendments

The Policyholder has the right to require amendments to the initial Insurance Policy conditions.

However, any amendment other than the ones clearly defined under articles 9 and 10 shall be subject to the Insurer's underwriting process the outcome of which may not be in line with the Underwriting terms applied at the Effective date of this Insurance Policy.

Article 13: Endorsement Validity

Any addition, deletion or any other amendment can only be considered as accepted by the Insurer when and if a relevant Endorsement is issued sealed and signed by the Insurer.

Article 14: Claims Notification

Refer to Claims Procedures and Settlement Section of this Policy.

Article 15: Claims Receivability

15.1 In-Hospital Family of Benefits:

It is agreed and understood that the liability of the Insurer is limited and restricted under this Insurance Policy to any In-Hospital Eligible Expenses incurred within the validity of this Insurance Policy.

15.2 Out-of-Hospital Family of Benefits:

It is agreed and understood that the liability of the Insurer is limited and restricted under this Insurance Policy to any Eligible Expenses incurred where the course of Treatment is within the validity of this Insurance Policy.

Article 16: Subrogation

Once the Insurance claim has been paid in accordance with the current terms, the Policyholder and Beneficiary subrogates his/her right to the Insurer to pursue any third party responsible for any Bodily Injury and transfer to the Insurer every relevant substantial and legal right. Both the Policyholder and the Beneficiary shall provide the Insurer with every possible assistance should the Insurer exercise the above right of subrogation. Should the Policyholder and the Beneficiary breach this obligation, they shall be responsible for any losses incurred by the Insurer.

Article 17: Cancellation

17.1 Policyholder's Right:

The Policyholder has the right to formally request the cancellation of this Insurance Policy

By doing so the Policyholder shall be the sole and fully liable party towards the Providers and/or the Insurer in respect of any expenses incurred by the Beneficiaries from the Cancellation Date of this Insurance Policy. The premium refund relating to the cancellation of this Insurance Policy will be calculated on a pro-rata basis for the period remaining after the Cancellation Date.

17.2 Insurer's Right:

The Insurer has the right to cancel the present Insurance Policy in the following instances:
a) Fraud, Abuse and false statements made by the Policyholder and/or Beneficiaries
b) Non-Payment of due Premium 30 days after the notification as per Article 7.
c) Reduction of 20% or more in Employee counts.
In the case of the Insurer legitimately cancelling this Insurance Policy, no Premium refund shall be due to the Policyholder unless cancellation is made in accordance with above in which case a pro-rata refund is due for the period remaining after the date.

Article 18: Arbitration

18.1 General Differences:

All differences relating to claim amount arising out of this Insurance Policy shall be referred to the decision of an arbitrator to be appointed in writing by the parties. If the parties cannot agree upon a single arbitrator, then two arbitrators should refer the matter for review, one to be appointed in writing by each of the parties. Should the two arbitrators fail to agree then the arbitrators should appoint an independent umpire in writing. The umpire shall sit with the arbitrators and preside at their meetings and the making of an award shall be a condition precedent to any right of action against the Insurer.

If the Insurer disclaims liability to the Beneficiary, his/her legal personal representatives or any claimant, for any claim hereunder, and such claim is not within 12 calendar months from the date of such disclaimer referred to arbitration under the provisions herein contained, then the claim shall be deemed for all purposes to have been abandoned and shall thereafter not be recoverable hereunder.

18.2 Medically Necessary Procedure:

In case of a difference between the NCC, acting as an independent administrator, and the attending Physician concerning the qualification of a service or Treatment as Medically Necessary, the parties can call for the arbitration of a Medical Committee, which will take the final decision. The Medical Committee shall be composed of three members - the attending Physician, the NEXtCARE Physician and a third independent Physician agreed upon by the first two.

The Committee will meet in neutral territory, and its decision will be taken by majority vote. This decision will be reported in duplicate documents, one for each party, and must be signed by all the Physicians. If any of the Physicians refuses to sign the documents, this refusal should be reported in the documents. The Insurer undertakes to accept the decision of this Medical Committee.

Article 19: Currency

Any money payable to or by the Company shall be in United Arab Emirates Dirhams.

Article 20: Change of Law

The laws of the United Arab Emirates govern this Insurance Policy. If following to an amendment of the law, which has come into force after the Effective Date of this Insurance Policy, a conflict has arisen with the conditions of this Insurance Policy the Insurer may, at its option, re-negotiate the conditions of this Insurance Policy from the date such amendment of the law becomes effective.

Article 21: Duties

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

SECTION F

CLAIMS PROCEDURES AND SETTLEMENT

The NEXtCARE Access card of each Beneficiary facilitated his/her access to any of NEXtCARE's participating Network Providers with no cash payment being required except when the Beneficiary has a deductible excess or co-participation to settle. The Beneficiary is always requested to carry his/her Emirates Id card to be presented to Providers whenever medical treatment is needed.

A Network Claim, as defined in this Policy, is the Eligible Expenses relating to Healthcare services rendered to the Beneficiary on a Free Access Basis arranged by NEXtCARE with the Network Provider on Direct Billing to the Insurer. This includes Healthcare services that are provided to the insured member within the Network either by the visiting and/or honorary and/or part-time and/or community physicians and/or healthcare providers; where the NEXtCARE contracted Network tariff shall apply.

A Direct Claim as defined in this Policy is the Eligible expense directly settled by the Beneficiary and submitted by the Policyholder to the Insurer for reimbursement. Eligible expenses are inclusive of co-insurance, if applicable.

Out of pocket limit is the maximum aggregate amount of eligible expense the beneficiary should bear during the policy year out of co-insurance options as per the Table of Benefits.

Second Opinion

Coverage of certain Treatment as Network Benefits may require that the Policy Holder/Insured Member consult a second Network Physician prior to the scheduling of the Treatment. The Insurer will notify Policy Holder/Insured Member that the particular Treatment can only be obtained subject to a Second Opinion and will inform the Policy Holder/Insured Member of the required procedure for obtaining a Second Opinion.

In case of a difference between the NEXtCARE physician acting as an independent administrator and the treating physician, concerning the qualification of a Treatment and/or service as medically necessary and/ or appropriate, the Insurer and/or Policy Holder/Insured Member can call for the Second Opinion, results of which will be final and binding.

1 IN-HOSPITAL DIRECTIVES

1.1 Within selected Territory

1.1.1 Network Claims

- If the Beneficiary chooses to be admitted in a Network Provider, upon presentation of the NEXtCARE Access Card, the Network Provider will directly co-ordinate with the NCC for authorisation.

- For non-emergency cases, the Beneficiary is requested to check with the Network Provider, prior to the scheduled In-Hospital, Day Hosp, or minor surgery/procedure, treatment/admission, if the Network Provider has received the authorisation from the NCC. The Beneficiary may directly contact the NCC to confirm authorisation.

- For emergency cases, upon receipt of the Hospital notification (NEXtCARE Pre-hospitalisation Form) from the Network Provider, the NCC shall immediately issue the authorisation for the eligible In-Hospital treatment.

- Outside U.A.E. the Beneficiary is requested to contact NEXtCARE Call Center at the numbers shown on NEXtCARE mobile Application or NEXtCARE website

- A NEXtCARE Medical and Claims Professional Staff will be receiving the call and shall provide specialised and necessary assistance for the Beneficiary's Hospitalisation and arrange for the eligible Hospitalisation expenses to be billed directly to the Insurer.

- Unlike in U.A.E. where the Beneficiary can directly approach a Local Network Provider, the International Network Providers require that each and every case be arranged by NEXtCARE prior to accepting a Beneficiary on free access basis / direct billing.

  The Beneficiary / caller is requested to provide the following information:
  1. His Name and NEXtCARE Access Card Number.
  2. His Telephone and Fax, when available.
  3. Name, Telephone and Fax, when available, of the treating Physician.
  4. Name of the Network Provider.
  5. Hospitalisation reasons.
  6. Date and Time of Admission.
  7. Other relevant information, which may be required.

- NEXtCARE shall fax to the treating doctor the NEXtCARE Pre-Hospitalisation Form, which must be completed by the Doctor and faxed back to NEXtCARE.

- Once NEXtCARE has received the medical information, a decision regarding the coverage of the Beneficiary's case shall be taken and the Beneficiary shall be informed accordingly.

- For disapproved cases, NEXtCARE shall issue a Denial Form informing the Network Provider, the Beneficiary/Policyholder and the Insurer that the admission is rejected and not eligible for coverage.

- When applicable, the Beneficiary is requested to settle directly to the Network Provider and prior to discharge any co-participation, non-Eligible Expenses like charges for telephone calls, additional food and/or any amount exceeding the Policy financial limit.

1.1.2 Direct Claims

- Reimbursement of Direct Claims as specified in the Benefit Description attached to the group policy wording

- Reimbursement of Eligible Expenses shall be effected upon submission of the required claims documents, as specified in Required Claims Documentation.

1.2 Outside Selected Territory:

Claims outside territorial scope are not covered, except for Elective and Emergency treatment as specified under the Table of Benefits

2 OUT-OF-HOSPITAL DIRECTIVES:

2.1 Within U.A.E.

2.1.1 Network Claims

- Upon presentation of the NEXtCARE Access card/Emirates ID to a Network Provider, the Beneficiary shall benefit from free access for Eligible Expenses relating to Out-of-Hospital services prescribed by the treating Physician except for any deductible and/or copayment if applicable, which should be settled by the Beneficiary directly to the Provider.

- For non-excluded diagnostic tests ordered by the treating Physician, the Beneficiary, is entitled to have the tests conducted as per the laid down prior approval protocol of NEXtCARE with network providers and mentioned under Table of Benefits. Please note that the protocol is subject to change by NEXtCARE time to time based on regulatory and administrative requirements

- For non-excluded medicines prescribed by the treating Physician, the Beneficiary is entitled to get the required quantity of the prescribed drug/s considered Medically Necessary for the treatment of acute diseases usually for a period of five to twelve days. Prior approval requirement is as per the laid down prior approval protocol of NEXtCARE with network providers and mentioned under Table of Benefit. Please note that the protocol is subject to change by NEXtCARE time to time based on regulatory and administrative requirements

- For chronic disease related medicines, when covered, the Beneficiary is entitled to receive the required quantity of the prescribed drug/s as prescribed by the treating physician; however quantity and duration of the course decide the prior approval requirement. Prior approval requirement will be as per the laid down protocol NEXtCARE with network providers and mentioned under Table of Benefits. Please note that the protocol is subject to change by NEXtCARE time to time based on regulatory and administrative requirements. Based on the duration of the treatment Beneficiary/Network Provider shall be requested to submit to NEXtCARE a medical report issued by the treating Physician including relevant investigation results explaining the Beneficiary's health condition and its history as well as the recommended treatment plan

- NEXtCARE shall issue an approval through any suitable administrative method on a monthly, quarterly or until the expiry date of the Insurance Policy depending on the medical condition of the Beneficiary, which may require some modification on the dosage, frequency or the drug it self.

- For non-excluded cases the requiring Physiotherapy prescribed by the treating Physician (not physiotherapist), NEXtCARE pre-approval is required before the service can be rendered to the Beneficiary.

- For non-excluded Dental treatment prescribed by the treating Physician, NEXtCARE prior approval is required before the service can be rendered to the Beneficiary

2.1.2 Direct Claims

Upon submission of original medical report(s), bill(s) and receipt(s), a Beneficiary is entitled to 100% reimbursement (subject to applicable deductibles and/or copayments as specified in the Table of Benefits) of Eligible Expenses if:

a) A Network Provider has refused to provide free access to the Beneficiary.
b) Free Access to the Network was suspended and then reinstated after the date of treatment.

All services from a Non – Network provider will be reimbursed as specified under the Table of Benefits

2.1.3 Out-of-Hospital Claims outside U.A.E

As per the relevant Benefit Description

3. Pre-Approval for Diagnostic/Therapeutic Procedures

Prior–approval from NEXtCARE is required for the certain diagnostic/therapeutic in-patient and outpatient procedures as specified in the Table of Benefits

4. a) **Required Claims Documentation for Direct Claims**

For the settlement of Eligible Expenses, the Beneficiary should submit to the Insurer the following documents within a maximum period of (60) days for claims incurred within UAE and (90) days for claims incurred outside the UAE from date of occurrence:

- ——Completed "Reimbursement Form" from the treating doctor
- Original itemised receipts of payment for the amount claimed (Invoice must shown cost per service)
- Full and Detailed Medical Report, Diagnosis, Discharge summary from the treating doctor or referral letter from treating physician wherever applicable
- Copies of results of diagnostic test.
- Valid Prescription by a physician for pharmacy related claims
- Police Report /First-hand information report in case of accident related claims.
- Valid Passport with Exit and Entry stamps to and from country of residence in case the claim is incurred outside country of residence.
- **All documents should be either in Arabic OR in English. If the reports/invoices are in any other languages must be translated prior to submission**.

Failure to submit any one of the above documents shall entitle the Insurer to reject the entire claim.

4 b) Resubmission period for in-completed reimbursement claims which are returned to the beneficiary:

For settlement of eligible expenses in case of resubmission of claims the beneficiary should submit to the Insurer the missing documents / information within a period of 30 days from the date of receipt of notification. Claim becomes time-barred for payment in future if resubmission is not within 30 days of receipt of notification

5. The insurer reserves the right to change and/or modify the Claims Procedures and Settlement at any time subject to (15) days notice to be given to the Policyholder by the Insurer.

The Insurer | The Policyholder

SECTION G

DEFINITIONS

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

Abroad	Any country other than the United Arab Emirates (U.A.E.).
Access Card/ Emirates ID	Emirates ID card issued by the Emirates Identity Authority or personalised card issued in the name of each Beneficiary, facilitating his/her access to the Healthcare services covered under this Insurance Policy and provided by the Network.
Accident	Any sudden and unforeseen event, occurring to a victim beyond his/her control and resulting in a Bodily Injury, the cause of which, is violent and external to the victim's own body.
Active at Work	The work situation of any Employee reporting regularly and on a permanent and full time basis to his work place and performing the usual and normal duties of his occupation in conformity with the employment conditions.
Application Form	Written statement of facts requested by the Insurer and duly completed and signed by the Policyholder, on the basis of which the Insurer will carry out an Underwriting in full accordance with the general provisions of this Insurance Policy. Two types of Application Forms are in use: **Initial Application Form**: The first Application filled by the Policyholder/ and or by his/her Legal Dependant(s) (as defined hereafter). **Subsequent Application Form**: Any form that the Policyholder completes, requesting the introduction of modifications to the Insurance Policy in force, and/or addition/deletion of Beneficiary (ies) in full conformity with the general provisions of this Insurance Policy.
Beneficiary	The Enrolled Employee or his Legal Dependant listed in the Application for this Insurance Policy, or included thereafter, formally accepted by the Insurer and listed in the Schedule or in any subsequent Endorsement thereon, are considered under this Insurance Policy as eligible and referred to as Beneficiary hereinafter.
Benefit	The smallest block of a Plan which is linked to a Family of Benefits and described by the Scope of Coverage.
Bodily Injury	An identifiable physical injury caused by an Accident, which occurred during the period of insurance.
Cancellation Date	The day (at 12:00 Midnight local time) month and year on which this Insurance Policy has been cancelled as a result of the Policyholder's written notice and/or as a result of the non-fulfilment of the Policyholder's

obligations as set forth in the general terms herein.

Category	The sub-group of Beneficiaries within the group covered under this Insurance Policy and for which the Policyholder has selected a Plan providing particular considerations as specified in the Schedules.
Chronic Disorder	An incurable disease requiring a regular, lifetime Treatment.
Claim	Information submitted by a Provider or by a Beneficiary to establish that medical services were provided to the Beneficiary, within the frame of the Benefits selected, and upon which processing for payment to the Provider or Beneficiary is made. The term generally refers to the liability of the Insurer for Healthcare services received by one of the Beneficiaries.
Congenital disorders	Congenital anomalies, also known as birth defects, are structural or functional abnormalities, including metabolic disorders, which are present from birth. Congenital anomalies are a diverse group of disorders of prenatal origin which can be caused by single gene defects, chromosomal disorders, multifactorial inheritance, environmental teratogens and micronutrient deficiencies.
Co-participation	The participation of the Beneficiary, Policyholder and/or a Co-Payer in accordance with pre-defined percentages in the payment of Eligible Expenses covered under this Insurance Policy. The Insurer shall be liable for the balance of the Eligible Expenses.
Co-Payer	An entity or a person participating jointly with the Insurer in the payment of an Eligible Expense, in accordance with a defined percentage as specified under the Partnership Schedule and/or the Policy documents
Day-Hospitalisation	Sometimes called Day-Care. Same day surgery, medical treatment or diagnostic tests including but not restricted to oncology (chemotherapy) and cardiology related to any Non-Excluded cases, not requiring an overnight stay at a Hospital but, nevertheless, necessitating specialised medical attention and care in a Hospital, before, during and after the Treatment.
Declared Condition	Any pre-existing Condition that was declared by the Policyholder in an Application Form or through any other means of official communication
Deductible Excess per Beneficiary	The accumulated amount of money relating to Eligible Expenses, and as specified in the Table of Benefits to be borne by the Policyholder on behalf of a specific Beneficiary in addition to Specific Deductible Excess and/or the Policyholder Co-Participation if and when applicable during the period of this Insurance Policy.
Deletion Date	The day (at 12:00 Midnight local time), month and year on which the Beneficiary'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 Employee or Legal Dependant no longer holds, or upon the cancellation of this Insurance Policy.
Disease	Medical condition/sickness/illness involving fever, pain, and/or malfunction of a bodily organ or function.
Denial Form	The form issued by the NCC for the attention of the Insurer, the Policyholder and the Network Provider denying eligibility of the Beneficiary and therefore denying Free Access on a direct billing basis according to the applicable Scope of Coverage.

Effective Date	The day (at 12.00 Midnight local time), month and year from which this Insurance Policy commenced.
Eligible Claim	Eligible Expenses net of Specific Deductible Excess, Co-Participation, Priority Payer share and Aggregate Deductible Excess, within the limits of liability of the Insurer as defined in the Schedules.
Eligible Expenses	All healthcare expenses incurred by a Beneficiary, relating to Non-Excluded Cases before allowing for any Specific Deductible Excess, Aggregate Deductible Excess, Co-Participation Priority Payer share and limits, within the limits of liability of the Insurer as defined in the Schedules.
Emergency	A sudden Sickness or Injury whose acute symptoms (including but not limited to severe pain) are of such severity that the absence of immediate treatment at a Hospital Emergency facility is medically expected to constitute a serious threat to the life, health, a bodily function and/or organ of the patient.
Emergency Treatment	Treatment required to save a life or alleviate danger to life
Employee	Any Active At Work person, working on a full time and permanent basis for the Policyholder and being remunerated accordingly. If any reason the employee is away ill at the policy commencement date, his/her insurance would not become effective until he/she resumes active employment.
Endorsement	Contractual document issued by the Insurer subsequent to this Insurance Policy, introducing alterations to this Insurance Policy in full conformity with its provisions.
Enrolled Employee	Any Employee covered under this Insurance Policy as the result of the Policyholder Application and the acceptance of the Insurer in conformity with the contractual procedure.
Enrolment Date	The day (at 12:00 Midnight local time) month and year, from when the first Insurance Policy became effective for a particular Beneficiary.
Exclusions	See General Exclusions.
Expiry Date	The day (at 12:00 Midnight local time), month and year on which this Insurance Policy expires.
Family of Benefits	A group of Benefits of one nature in term of utilisation and Treatment (e.g. Family of In-Hospital Benefits, Family of Out-of-Hospital Benefits)
First Effective Date	The day (at 12.00 Midnight local time), month and year from which the first Insurance Policy became effective for this Policyholder.
Free Access	The Insurer undertaking of direct settlement to the Network Providers of an Eligible Claim incurred by a Beneficiary.
General Exclusion	The Exclusions, which are applicable under this Insurance Policy to all Benefits and shown in the General Exclusions List.
Hazardous Activity	Any physical activity exposing the Beneficiary to a serious Injury in case an unexpected accident occurs during the course of this physical activity, as described in the General Exclusions list.

Hospital	Any medical institution, public or private, which is legally licensed to provide medical treatment to sick and/or injured persons. The facility must consist of organised premises, possess the necessary technical and scientific equipment for diagnosis and surgical operations, and provide healthcare services 24 hours a day by a staff comprising at least one resident Physician and qualified nurses. The term "Hospital" excludes Outpatient clinics, sanatoria, physiotherapy centres, health clubs, retirement homes, nursing homes, and similar institutions, including those specialising in substance abuse (drugs, alcohol).
Hospital Confinement	An uninterrupted stay for a defined period of time in a Hospital at least overnight.
Hospitalisation	Any Hospital Confinement, for a minimum of one night, of Medically Necessary Treatment/ observation, of any Non-Excluded Disease or Bodily Injury necessitating specialised medical attention and care in a Hospital before, during and after the Treatment/observation, and which cannot be performed on an Out-of-Hospital basis.
Hospitalisation Class	The class of Hospital accommodation services which the Policyholder has selected on behalf of the Beneficiary to be applied for his/her Hospital Confinement and which are identified in the Policy Schedule in accordance with the following coding:
Illness	See Disease.
In-Hospital Treatment	A Hospitalisation or Day-Hospitalisation-or Treatment and/or observation in an Emergency Room in a Hospital.
In-Patient	A patient who occupies a bed overnight, or been formally admitted as a Day-Hospitalisation patient in a Hospital.
Insurance Policy	The particular arrangement of Plans/Programs as described by this Insurance Policy, the Schedules, Scope of Coverage and Endorsements which constitute the full agreement.
Insurance Policy	The contract, or the Insurance Policy, (as defined in Article 1 of the General Terms and Conditions) whereby the Insurer, subject to the terms, provisions, limitations, exclusions and other conditions provided herein, guarantees the payment of the Benefits set forth in the Schedules.
Insurer	Tokio Marine and Nichido Fire Insurance Co. Ltd
Legal Dependants	The unmarried children who are under 18 year old, or below 25 if still a full-time university student, and the Spouse(s) of the Enrolled Employee.
Maternity	Hospital Confinement for Normal or Caesarean-Delivery, Medically Necessary abortion or miscarriage and/or any complications arising wherefrom, ante- and postnatal Treatment as Medically Necessary.
Medically Necessary	A service or Treatment, which, in the medical opinion of the NCC, is appropriate and consistent with diagnosis, and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the Beneficiary's condition or the quality of medical care rendered.
NEXtCARE	NEXtCARE is a managed care organisation and appointed to act in the name and on behalf of the Insurer in administering this Insurance Policy in

part. Among other management services, NEXtCARE interfaces with the Beneficiary through a NEXtCARE Call Center (referred to hereinafter as NCC).

NEXtCARE Call Center Professional service Center operating 24 hours, all year round, staffed with a team of Medical and Claims administrative specialists working for NEXtCARE to support and monitor the proper application of the Insurance Policy. The NCC provides Beneficiaries and Providers with medical and procedural guidance and information through telephone inquiries; advises claims and membership eligibility; carries out pre-approval reviews; provides appropriate authorizations; takes decision in the name and on behalf of the Insurer as to whether or not grant Free Access to the specific healthcare service under consideration and evaluates submitted claims in order to approve payment.

Network Providers forming the NEXtCARE Network(s) through a special and formal contractual arrangement whereby they agree to avail the Beneficiary, usually on his Access Card presentation, with Free Access on a direct billing basis to their healthcare services in conformity with the terms of this Insurance Policy and as set forth in the Policy Schedule

Non Excluded Cases Any specific Illness or Treatment that is covered, and not listed under the General Exclusions.

Non-Network Provider Any Providers that are not part of the Network.

Out-of-Hospital Physician's consultation, prescribed drugs, diagnostic tests and Treatment not requiring Hospitalisation nor necessitating specialised medical attention and care in a Hospital before, during and after the procedure.

Out of pocket limit Out of pocket limit is the maximum aggregate amount of eligible expense the beneficiary should bear during the policy year out of co-insurance options.

Partnership Schedule In which additional information is specified (Priority Payer details if any, Co-Payer percentages, etc).

Physician Any doctor of medicine (MD) duly licensed and qualified to render the Treatment provided under the law of jurisdiction in which such Treatment is provided.

Plan The combination of Benefits offered by the Insurer and selected by the Policyholder on the Application Form.

Policyholder Initially the applicant for this Insurance Policy acting in the name and on behalf of, his Employees and their Legal Dependants whose Application has been formally accepted by the Insurer. By virtue of acceptance, this Insurance Policy has been issued and the applicant becomes the Policyholder.

Policy Schedule In which all Beneficiary and the Insurer information are specified, together with the specific conditions of this Insurance Policy (the Contractual Parties' Data, the Effective Date, the Expiry Date, the Beneficiaries Date, the Enrolment Dates, the Category, the Specific Exclusions and related waiting periods if any, the Lifetime Limits when applicable, the Hospitalisation Class, the Selected Plans, the Premium, the Frequency of Payment and any reference(s) to other schedule(s).

Pre-existing Condition	Any illness, sickness, disease or other physical, medical, mental or other condition, disorder or ailment where, in the opinion of a medical practitioner appointed by the Insurer, signs or symptoms of the condition existed at any time in the period prior to the Insured Member becoming insured under the Policy. The test applied relies upon signs or symptoms of the condition being present and not on an eventual diagnosis. It is not necessary for the Insured Member or his doctor to know what their condition is or was at the time of taking out the policy. In forming an opinion, the Insurer appointed medical practitioner who makes the decision must take into account information provided by the Insured Member's treating doctor.
Premium	The periodic payment required for providing coverage and to keep the Insurance Policy in force.
Priority Payer	An entity identified under the Partnership Schedule as being the first party fully liable towards the Eligible Expenses of a specific Beneficiary up to a certain limit, which is specified under the Partnership Schedules. The Insurer shall be liable to pay any amount of any Eligible Expenses exceeding this limit.
Program	The combination of Plans offered by the Insurer and selected by the Policyholder on the Application Form.
Proof of Insurability	The process of completing an Application form and submitting it to the Insurer for Underwriting.
Providers	A generic term for Physicians, Hospitals, Clinics, Medical Centres, Pharmacies, Laboratories, Physiotherapy Centres, and other Paramedical Institutions or Persons who are licensed to offer healthcare services.
Renewal	New coverage under a new Insurance Policy following a previous term and the acceptance of a Premium for a new Insurance Policy insurance period.
Renewal Date	The day (at 12:00 Midnight local time) month and year on which a Renewal takes place and which coincides with the Expiry date.
Schedule	Technical addenda forming an integral part of this Insurance Policy which further define the details of this Insurance Policy. The Policy Schedule, the Scope of Coverage Schedule and the Table of Benefits (where applicable)
Scope of Coverage Schedule	In which the Plan/Program selected by the Policyholder on behalf of the Beneficiaries is specified showing for each Family of Benefits: Coverage, Limits, Deductible Excess, Co-Participation, etc. May sometimes also be referred to as the *Table of Benefits*
Second Opinion	Second opinion is an opinion obtained from an additional health care professional of to the same clinical standing and specialty. This opinion maybe either prior to or after the performance of a medical treatment or surgical procedure, whereby it will then confirm the diagnosis, medical necessity and/or appropriateness of the Treatment given.
Sickness	See Disease.
Specific Deductible Excess	The amount of money stated in the Applicable Scope of Coverage Schedule to be borne by the Policyholder in respect of the particular service under consideration.
Substandard Terms	Special terms under which a Beneficiary is covered under this Insurance

	Policy (i.e. Additional Premium and/or special limits and/or Waiting Period) as a result of an Underwriting.
Surgery	Any invasive procedure, including laser use, whose aim is to diagnose/cure disease or damage and/or rectify a defect or malformation. In this connection, invasive diagnostic procedures such as endoscopy, cauterisation (with the exception of rhino gastric, urethral, peripheral venous and/or arterial), angiography as well as destruction of kidney or gallstones will be considered as Surgery.
Table of Benefits	Describes the scope of cover and modalities of claims payment and is part of the contract
Territory	The country (or group of countries) as selected by the Policyholder to allow Beneficiaries to access Benefits defined in the Table of Benefits
Territory of Occurrence	The country where the Beneficiary's health conditions have required healthcare services and where the related expenses were incurred.
Treatment	A generic term to include all healthcare services provided under this Insurance Policy, including In-Hospital Treatment and Out-of-Hospital Treatment and embracing all In-Patient services, Out-Patient Consultations, Diagnostic Tests and Procedures, prescription of medicines, minor surgery and procedures, physiotherapy, dental care, etc.
Undeclared Pre-Existing Condition	The non-disclosure or error by the Beneficiary and/or from the Policyholder acting on behalf of the Beneficiaries, in completing any part of the Application for this Insurance Policy, of Pre-existing Conditions relating to health, (symptoms, diagnosis, conditions), or any other details (explicitly or implicitly).
Underwriting	The process of evaluation to which the Insurer submits all Application Forms prior to issuance of the Insurance Policy and any other subsequent related Endorsement in full conformity with the provisions of this Insurance Policy.
Unnecessary Treatment	A service or Treatment, which is not Medically Necessary.
Waiting period	The period of time starting from the first Enrolment Date of the Beneficiary during which an Exclusion is in force under a specific benefit covered under this Insurance Policy.
Waiver Date	The date of termination of the Waiting Period after which an Exclusion is deleted.