Policy Terms and Conditions

MyHEALTH Qatar Individual Medical Plans

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INSURANCE & REINSURANCE

April International

1. OUR CONTRACT WITH YOU

1.1. These terms and conditions need to be read together with the policy pack, the Benefits Schedule, and any endorsement(s).
All of these documents, together with the statements made in your application and any documents or statements submitted in connection with or referred to in your application make up the entire policy.

1.2. No change to the policy will be effective unless contained in a written endorsement signed by us.

2. FREE LOOK PERIOD

2.1. Please examine the policy carefully to make sure You have the cover You want. If You have any questions about the policy, please contact us or the person who arranged this policy for you.
Within 14 days of receiving this policy, You may return it to us for a full refund of any premium paid, provided that no Claim has been made during this period. The policy will be deemed void from the Effective Date.

3. WHO IS COVERED?

3.1. You and your Dependants whose names appear on the policy pack.

3.2. The maximum permitted age at the date of joining this policy is 65 years old.

4. WHERE ARE YOU COVERED?

4.1 This policy provides cover only for services rendered within the area of cover stated in the Benefits Schedule, except as expressly provided below.

4.2. Where out of area cover is expressly provided in the Benefits Schedule, We will cover Medically Necessary treatment received outside the selected area of cover, subject to:

- the maximum monetary limit shown in the Benefits Schedule (if applicable);
- the maximum number of days of treatment shown in the Benefits Schedule, calculated from the date treatment first commences; and
- the requirement that such treatment arises from a Sudden Illness or Injury occurring during the permitted travel period stated in the Benefits Schedule.

Out of Area Cover does not apply to any trip:

4.2.1. commenced or continued against the orders or advice of any Physician; or

4.2.2. undertaken in whole or in part for the purpose of obtaining medical care.

5. NETWORK AND PROVIDER ARRANGEMENTS

5.1. Where the Benefits Schedule indicates that cover is subject to a selected network option, coverage shall apply in accordance with the network level chosen (e.g. Standard or Premium).

5.2. The following definitions shall apply for the purposes of this policy:

5.2.1. Network Providers means medical providers within our designated network at which coverage is available in accordance with the selected network option.

- Premium Network means coverage at all medical providers.
- Standard Network means coverage at all medical providers, except for designated providers where a co-insurance percentage, as stated in the Benefits Schedule, shall apply

5.2.2. Panel Network Providers means medical providers identified as such in our current Outpatient Direct Billing network list.

5.3. The level of coverage within each network option, including any applicable co-insurance or provider restrictions, shall apply in accordance with the network option selected and as specified in the Benefits Schedule.

5.4. Where an outpatient module includes access to a panel network, services rendered by Panel Network Providers may be eligible for direct billing and/or reduced co-insurance as specified in the Benefits Schedule.

5.5. The composition of any Network Providers or Panel Network Providers may change from time to time. The most up-to-date list of providers is available via the link specified in the Benefits Schedule or upon request. Changes to the provider list shall not constitute a change to the policy terms.

6. PERIOD OF COVER

6.1 The minimum initial Period of Insurance is 12 months.

6.2 Subject to renewal in accordance with these Terms and Conditions, each subsequent Period of Insurance shall also be for 12 months.

7. WAITING PERIODS

7.1. Cover for the following benefits will commence only after the applicable Waiting Period has been completed, calculated from the date on which the Insured Person first becomes entitled to the relevant benefit under this policy, including where such benefit is added or upgraded at renewal. No benefit shall be payable for any Expense incurred before completion of the applicable Waiting Period. Completion of a Waiting Period shall not reset upon renewal of the Policy, provided the Insured Person maintains continuous entitlement to the relevant benefit.

7.1.1. Maternity benefits and Fertility Treatment: after 366 days;

7.1.2. Major Dental Treatment and Orthodontic treatment: after 180 days;

7.1.3. HIV/AIDS benefits: coverage will apply only if signs or symptoms first appear after three (3) years;

7.1.4. Laser Treatment for Vision Correction benefit: after 366 days.

7.2. If You change the cover for an Insured Person after the start of the first Period of Insurance, the benefits payable for any Disability or service subject to a Waiting Period shall be limited to those shown in the Benefits Schedule applicable at the start of that Waiting Period or those shown in the current Benefits Schedule, whichever is lower.

8. NEWBORN ADDITIONS

8.1. A Newborn Infant born to a mother who has been covered under the policy for more than 366 consecutive days may be added to the policy from birth without medical underwriting, provided that the Newborn Infant was not born following Major Assisted Conception.

8.1.1. You must notify us by submitting the newborn addition form within 28 days of birth so that We can add the child to the policy. The premium for the Newborn Infant must be paid in accordance with Paragraph 9.

8.1.2. Your child's cover will match the cover provided to the mother on the first day of the twelve-month period preceding the child's birth, excluding any optional cover chosen for Maternity Benefits or Dental and/or Optical Benefits. Cover for Neonatal Disabilities will be limited to the Neonatal Disabilities limit shown on the Benefits Schedule.

8.2. A child not meeting the criteria under 8.1 must be added by medical questionnaire, including any child:

8.2.1. whose mother has not been covered under the policy for 366 consecutive days;

8.2.2. for whom a newborn addition form was not received by us within 28 days following birth;

8.2.3. who was adopted or was carried by a surrogate; or

8.2.4. who was born through Major Assisted Conception.

8.3. Our underwriting process will apply to an addition under article 8.2, and We may decline to provide cover or may offer cover on such terms as We require.
The cover must be equal to the cover provided to the mother (or the father if the mother is not covered under this policy), excluding any optional Maternity Benefits, Dental and/or Optical Benefits. The start date of coverage for the child will be the date on which the underwriting results are finalised.

9. PREMIUM PAYMENT

9.1. We must receive the premium on or before the due date stated on the debit note.

9.2. For the first premium payment of each policy year:

9.2.1. if the premium is received after the due date but before 11:59pm Qatar time on the 30th day following the due date, the policy will automatically be reinstated. If the premium is not received within that 30-day period, the policy shall lapse.

9.2.2. if the premium is received after the 30th day following the due date, it will be treated as an application for reinstatement of coverage, and additional proof of insurability may be required.

9.3. If any premium due is not paid, We reserve the right to recover any Claims already paid in accordance with Paragraph 18.

10. RENEWAL OF YOUR POLICY

10.1. Unless You notify us in writing on or before the last day of the Period of Insurance that You do not wish to renew the policy, We will send You a renewal offer at least 30 days prior to the end of the current Period of Insurance. Renewal is subject to payment of the premium in accordance with the Paragraph 9. The premium for the renewal policy will reflect the age of Insured Persons on the first day of the renewal Period of Insurance and other factors affecting the cost of insurance. The Free Look Period does not apply upon renewal of the Policy.

10.2. We reserve the right, at renewal, to change:

10.2.1. the terms, conditions, and benefits of the policy, by giving You written notice of such changes not less than 30 days prior to the end of the current Period of Insurance, provided that such changes apply to all policies of the same plan type;

10.2.2. the premium, to reflect the risk associated with insuring you, including changes based on your Country of Residence, by giving You written notice prior to the end of the current Period of Insurance.

10.3. If, after receiving notice under article 10.2 You do not wish to renew your policy, You must notify us prior to the last day of the Period of Insurance. Otherwise, the policy will be renewed on the revised terms and conditions.

10.4. This shall not affect any right We may have to cancel the policy or to decline renewal, including but not limited to those provided for in the Paragraph 12.

11. CANCELLATION

11.1. The minimum period of insurance is 12 months.

11.2. You may cancel the policy during a Period of Insurance. However, no refund of premium will be made except as provided under Paragraph 2.

12. MATERIAL CHANGES

12.1. As a condition precedent to liability, You must inform us as soon as reasonably practicable of any change in your name, occupation, the country(ies) of which You hold a passport or citizenship, or your Country of Residence. Such a change may result in an adjustment of the applicable premium and, in certain cases, termination of cover without refund. If such notice is not given, We will have no liability under this policy for Expenses occurring after the date of such change.

12.2. You must inform us as soon as reasonably practicable of any change to your residential address or correspondence address. Until such notice is given, We may continue to send correspondence to the last address provided to us, and shall not be responsible if such correspondence is not received by you.

12.3. If your Country of Residence changes to the United States of America, We reserve the right to cancel the policy and without premium refund.

13. PROOF OF CLAIM AND COOPERATION

13.1. As a condition precedent to liability, all Claims for reimbursement of Expenses must include the following (the "required claim documents"):

13.1.1. bills and supporting documents showing the breakdown of Expenses and the diagnosis of the condition treated; and

13.1.2. evidence of payment made by you.

13.2. All required claim documents must be received by us within 365 days from the date the service was rendered or within 45 days from the date the policy is terminated, whichever occurs first. Where it is not reasonably possible to present the required claim documents within this period, they must be received by us within 365 days from the date You incurred the Expense.

13.3. Claims may be submitted to us:

13.3.1. via the April Easy Claim smartphone app;

13.3.2. by email to CSR-APRIL@seibinsurance.com, together with copies of the required Claim documents; or

13.3.3. by mail to our address, attaching original documents.

13.4. If You submit Claims by email or via the April Easy Claim smartphone app, You must retain a copy of the original documents for a minimum period of one year from the date You submit the Claim and must provide the original documents to us upon request or in accordance with our Claim instructions.

13.5. You must fully cooperate with us and our appointed agents in connection with any Claim. Such cooperation may include, but is not limited to, providing original documents upon request, or providing any consent We reasonably require to obtain information relevant to your Claim from any source, including a Physician, or other medical provider, Hospital, or insurance company.

13.6. If We request for cooperation, documents, information, or consent to obtain documents or information, it shall be a condition precedent to liability that You provide the requested cooperation, documents, information, and consent reasonably required, in a timely manner, and for us to assess the Claim.

13.7. No benefit shall be payable where an Insured Person has failed to comply with a material term, condition or procedural requirement of this policy to the extent that such failure has prejudiced our ability to assess the Claim or protect our rights.

14. PROCESS TO OBTAIN PRE-AUTHORISATION

14.1. As indicated in the Benefits Schedule, certain services require Pre-authorisation, including but not limited to:

- hospital benefits;
- cancer treatment;
- Surgery performed while a Day-patient in a Clinic or in a Physician's office;
- Stem Cell Treatment;
- Rehabilitation Treatment.

14.2. Co-payment for Pre-authorisation outside the USA:
- A 20% co-payment applies to services requiring Pre-authorisation where such Pre-authorisation has not been obtained.

This co-payment shall not apply where You can demonstrate that the services were Medically Necessary due to an Emergency and You or the Hospital contacted us within 24 hours after admission or as soon as reasonably practicable.

14.3. Co-payment for planned Hospitalisation or surgeries in the USA:
- A 40% co-payment applies to services rendered outside our preferred USA network.
  This co-payment shall not apply where You can demonstrate that the services were Medically Necessary due to an Emergency and You or the Hospital contacted us within 24 hours after admission or as soon as reasonably practicable.

14.4. To obtain Pre-authorisation, You must submit your request via the April Easy Claim smartphone app or by email to provider.asia@april.com at least 5 working days before admission or treatment.

14.5. Upon receiving your request, We will review the Medical Necessity and appropriateness of the requested service and within five working days whether we:
- grant Pre-authorisation;
- deny Pre-authorisation; or
- request further information.
- Pre-approval may be partly given and partly denied.

14.6. If within five working days of receiving a complete request, Pre-authorisation is not given or denied, or additional information is requested, then such service shall not be subject to the co-payment applicable to services for which Pre-authorisation was not obtained.

14.7. If We request further information, You must provide the requested information in a timely manner. Article 13.5 and Article 13.6 apply.

14.8. Pre-authorisation is not a guarantee of benefits or eligibility. All services remain subject to benefit limits, exclusions and other terms of the policy. Pre- authorisation may be revised or withdrawn if We later determine that the service is not covered or is not Medically Necessary.
Pre-authorisation applies only to the specific service approved. Additional services, even if related to the same Disability, require separate Pre-authorisation.

14.9. If an extension of the length of stay is required, You must contact us before the approved period expires.
If You fail to do so, services rendered after the approved period shall be subject to the co-payment applicable to services for which Pre-authorisation was not obtained.

14.10. If Pre-authorisation is denied, You may submit one appeal.
We will review the appeal and notify You of our determination or request further information within five working days of receiving the appeal.

14.11. Particular provisions applicable to certain medical conditions:

14.11.1. In the case of treatments related to sleep disorders (for both children and adults), our medical team retains sole discretion to determine whether a proposed treatment or surgical procedure is related to a sleep disorder, including but not limited to Sleep Apnoea and chronic snoring, in both pediatric and adult cases. This determination may be made even in the absence of a formal sleep study. The absence of diagnostic testing shall not preclude the classification of a treatment as sleep disorder-related if clinical indicators and medical judgment support such a conclusion.

14.11.2. In cases of surgical procedures involving septoplasty and/or rhinoplasty, these procedures must be subject to a mandatory Second Medical Opinion (SMO) review conducted by Teladoc. Coverage will only be granted if the procedure is deemed Medically Necessary by both our medical team and Teladoc's Second Medical Opinion panel. Standardized clinical questions will be incorporated into the Second Medical Opinion report to ensure consistency and transparency in decision-making.

15. RIGHT TO EXAMINE AN INSURED PERSON

15.1. We are entitled to require an Insured Person to undergo a medical examination at our expense by a Physician of our choosing. If an Insured person dies, we are entitled to require a post-mortem examination at our expense unless prohibited by law.

16. CO-INSURANCE AND DEDUCTIBLES

16.1. All Expenses shall be paid in excess of any Deductible that applies and after application of any Co-insurance Percentage (also known as co-payment percentage).

17. CLAIMS AGAINST THIRD PARTIES OR OTHER INSURANCE

17.1. If another medical or accident insurance covers You for Expenses relating to a Disability also covered by this policy, You must claim from that other source first. We shall only be liable for the excess of the amount recoverable from such other source. Amounts paid by another source may be applied toward your Deductible, provided that proof of payment is submitted to us.

17.2. If another person or entity may have be liable for your Expenses, including but not limited to a third party who is responsible for an Injury, You must take all reasonable steps to seek reimbursement from that person or entity before claiming from us.

17.3. You must not negotiate, settle, compromise, release or otherwise discharge any claim You may have against any third party who may be liable for your Expenses without our prior written consent. Failure to obtain our prior written consent will result in us having no liability for any Expenses that could have been recovered from that third party.

17.4. In the event of any payment under this policy, We shall be subrogated to your or any Insured Person's rights of recovery against any other person or entity. We may take proceedings in your name, but at our expense, to recover any amount paid under this policy. Neither You nor any Insured Person shall do anything likely to prejudice such recovery and instead shall take all reasonable steps to assist us in obtaining such recovery.

18. RIGHT OF RECOVERY

18.1. If We pay, guarantee, or authorise payment of Expenses, or if You obtain treatment through our direct billing network, and We later determine that You were not entitled to that payment for any reason, We reserve the right to recover the amount paid from you.

18.2. If premiums due have not been paid in accordance with Paragraph 9, We may deduct any outstanding premium from any Claims payable or any amount otherwise due to You under this policy until such outstanding amounts have been fully satisfied. Exercise of this right shall be without prejudice to any other rights or remedies available to us under this policy or at law.

19. OWNERSHIP AND SUCCESSOR POLICYHOLDER

19.1. Expenses will be paid to You or your legal representatives, whose receipt shall fully discharge our liability for those Expenses. We may, at our discretion, pay Expenses to a provider of services unless You or your legal representative have instructed us in writing not to do so and We have not agreed to pay the provider prior to receiving such instruction.

19.2. If the Policyholder dies during the Period of Insurance, then, in the following order of priority, the surviving spouse or, if there is no surviving spouse, the eldest Insured Person then covered by the policy (or their legal guardian, if a minor), shall automatically become the Policyholder.

19.3. Unless an endorsement states otherwise, We shall treat the Policyholder as the absolute owner of this policy and We are not required to recognise any other Claim to or interest in this policy.

20. IN THE EVENT OF FRAUD OR NONDISCLOSURE

20.1. We may cancel the policy from its inception and retain the premium, if:

20.1.1. you, an Insured Person, or anyone acting on your or their behalf, provided false information to us or failed to disclose information in connection with your application, any application to add an Insured Person, an upgrade of cover, or reinstatement, and such misrepresentation or non-disclosure was fraudulent; or

20.1.2. any Claim is fraudulent in any respect, or fraudulent means or devices are used by you, an Insured Person, or anyone acting on your or their behalf to obtain benefits under this policy.

20.2. We reserve the right to re-underwrite your application if any Claim relates to Pre-existing Conditions that was not disclosed in the application.

20.3. If this policy is cancelled due to fraud or nondisclosure after Claims have been paid or after We have provided a guarantee of payment to a provider of services, We reserve the right to recover from You any amounts paid or guaranteed.

21. SANCTIONS AND COMPLIANCE WITH LAWS

21.1. We reserve the right not to accept applications for cover or to cease providing cover if doing so would expose us to the risk of breaching any applicable law or regulation, including international economic sanctions.

21.2. For the avoidance of doubt, We shall not be deemed to provide cover and shall not be liable to pay any Claim or provide any benefit under this policy to the extent that the provision of such cover, payment of such Claim, or provision of such benefit would expose us 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, United States of America, the laws of the State of Qatar, France, or any other jurisdiction applicable to us.

22. GOVERNING LAW AND JURISDICTION

22.1. This policy is governed by, and is to be interpreted according to, the laws of Qatar and subject to the exclusive jurisdiction of the Qatar courts.

22.2. Any person or entity who is not a party to this Policy shall have no rights to enforce any terms of this Policy.

22.3. By subscribing to this policy, You give consent to Seib Insurance & Reinsurance Company LLC and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to you or other individuals that you have furnished via any means in the past, present & in the future, for one or more of the purposes described in its Personal Information Collection Statement available at https://www.seibinsurance.com/wp-content/uploads/2022/02/Privacy-statement.pdf

22.4. You warrant that all personal data You have provided is accurate and complete, and You shall inform us as soon as reasonably practicable of any changes to such personal data.

22.5. Personal data shall be processed in accordance with applicable Qatar data protection laws and the QFC Data Protection Regulations and used solely for lawful purposes relating to this policy.

23. COMPLAINT

23.1. Any Insured Person complaint relating to the services provided or products offered may be submitted to Seib Insurance and Reinsurance Company LLC. Complaints will be handled fairly and promptly in accordance with the Company's complaints-handling procedures.

Complaints may be submitted by telephone at (+974) 4402 6863 / 4402 6888, by email to complaints@seibinsurance.com, or by post to P.O. Box 10973, Doha, Qatar. The Company will acknowledge receipt within five (5) business days and provide a response within a reasonable timeframe. If the Insured Person remains dissatisfied, the complaint may be referred to the QFC Customer Dispute Resolution Scheme (CDRS) at complaints@cdrs.org.qa or P.O. Box 22989, Doha, Qatar

24. EXCLUSIONS

24.1. **General & Policy Eligibility Exclusions**
Applies to all benefits unless expressly stated otherwise in the Benefits Schedule.

24.1.1. All Expenses incurred in respect of treatment, services, tests or supplies which are not Medically Necessary, as defined in this Policy, or which are not clinically appropriate to the diagnosed condition.

In particular, reimbursement of all Expenses incurred in respect of the use of robotic surgery where such use is not Medically Necessary and where a clinically appropriate conventional alternative is available. In such cases, reimbursement shall be limited to the Reasonable and Customary cost of the equivalent conventional treatment.

24.1.2. All Expenses which are not Reasonable and Customary, considering the country in which they were incurred.

24.1.3. All Expenses incurred in respect of treatment, services, medicines or supplies which are not prescribed, ordered or provided by a duly qualified and licensed Physician or healthcare provider.

24.1.4. All Expenses incurred in respect of Advanced Therapy Medicinal Products (ATMPs), including but not limited to gene therapy, cell therapy or tissue-engineered products, unless such treatment is expressly covered under the Advanced Therapy Medicinal Products (ATMPs) benefit.

24.1.5. All Expenses incurred in respect of experimental, unproven, unlicensed or unapproved medicines, drugs or treatments, or medicines not recognised as effective by generally accepted medical practice, unless expressly covered under the Experimental Treatment benefit.

24.1.6. All Expenses incurred in respect of Inpatient or Day-patient treatment that can be provided on an Outpatient basis.

24.1.7. All Expenses incurred in respect of treatment, services or supplies provided or prescribed by the Insured Person, a member of their immediate family, or by an entity in which the Insured Person or an immediate family member has a direct or indirect ownership interest.

24.1.8. All Expenses incurred in respect of non-medical personal items, including but not limited to telephone charges, internet access, television, newspapers, guest meals and similar comfort or convenience items.

24.1.9. All additional Expenses arising from accommodation, room category or services in excess of those covered under the Benefits Schedule.

24.1.10. All Expenses incurred in respect of the issuance of medical certificates, reports or attestations, medical examinations conducted for administrative, employment, insurance or travel purposes, and any related administrative fees or charges, including charges for the provision of claim forms or medical records, whether in paper or digital format, including but not limited to electronic files, thumb drives, compact discs or photographic prints.

24.2. **Pre-existing Conditions & Underwriting Basis**
Applies in accordance with the underwriting basis stated in the Policy and/or Certificate of Insurance.

24.2.1. All Expenses incurred in respect of any Pre-existing Condition, unless such condition has been declared to and accepted by the Insurer in writing in connection with the Insured Person's application for cover or any subsequent application to add or upgrade benefits, and is expressly covered under the Policy. (applies only to fully underwritten policies).

24.2.2. All Expenses incurred in respect of any medical condition, complication, symptom or consequence directly or indirectly related to an excluded Pre-existing Condition.

24.3. **Time & Policy Mechanics**

24.3.1. No benefits shall be payable for any Expenses incurred:
- before the date on which the Insured Person becomes entitled to benefits under the Policy;
- after the expiry, termination, cancellation or suspension of the Policy or the Insured Person's cover, including any medicines, medical supplies, treatment or services provided or consumed after such date, even if prescribed, ordered or initiated during the Period of Insurance;
- during any period for which the required premium has not been paid; or
- at any time when the Insured Person is no longer eligible for cover under the Policy.

24.4. **Uninsurable Events & Systemic Risks**
Risks which are inherently uninsurable or fall outside the scope of private medical insurance.

24.4.1. All Expenses incurred in respect of Disability, Illness, Injury or treatment resulting from:
- ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;
- the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component thereof;
- any weapon of War employing chemical or biological force, atomic or nuclear fission and/or fusion or other like reaction or radioactive force or matter.

24.4.2. All Expenses incurred directly or indirectly as a result of War (whether declared or not), invasion, acts of foreign enemies, hostilities, civil War, rebellion, revolution, insurrection, terrorism, riots, strikes, lockouts, brawls, civil commotion or similar disturbances.

24.4.3. All Expenses incurred as a result of participation in military service, warlike operations or armed conflict, whether in a regular or irregular force.

24.4.4. All Expenses incurred in respect of Injury, Illness or Disability arising from active service in any military, paramilitary, police or security force.

24.4.5. All Expenses incurred in respect of any service rendered while the Insured Person is detained, imprisoned or confined as an inmate of a prison, jail, penal institution, correctional facility, halfway house or any similar facility.

24.4.6. All Expenses incurred in respect of treatment or care provided in a mental institution where such care is Custodial in nature rather than active medical treatment.

24.4.7. All Expenses incurred in respect of artificial life maintenance, including mechanical ventilation, or treatment provided in the context of a persistent vegetative state or other irreversible neurological condition, where such treatment will not or is not expected to result in recovery or to restore the Insured Person to their previous state of health.

24.4.8. All Expenses incurred in respect of Hospice or Palliative Treatment, unless expressly covered under the Hospice or Palliative Treatment benefit in the Benefits Schedule.

24.5. **Intentional, Illegal & Substance-Related Acts**

24.5.1. All Expenses incurred in respect of suicide, attempted suicide, self-inflicted Injury or Illness, or any related attempt, whether self-inflicted or agreed with other persons, whether or not the Insured Person was conscious or suffering from a mental disorder at the time.

24.5.2. All Expenses incurred in respect of treatment, care or tests directly or indirectly related to any loss, Injury, Illness or medical condition arising from the Insured Person's own act while under the influence of alcohol, liquor, addictive, psychoactive, narcotic drugs or any similar substances, where the Insured Person is unable to properly control their actions or remain conscious.
This exclusion applies whether or not a blood alcohol test is performed. In the event of a blood alcohol test, "under the influence of alcohol" refers to a blood alcohol level equal to or exceeding 150 mg per 100 ml of blood, unless a lower or higher legal limit is established under applicable local law, in which case such legal limit shall apply.

24.5.3. All Expenses incurred in respect of treatment, care or tests directly or indirectly related to any loss, Injury, disease or medical condition arising from or attributable to drug dependence, smoking addiction or alcoholism, unless expressly covered under the Alcohol and Substance Abuse benefit in the Benefits Schedule.

24.5.4. All Expenses incurred in respect of any loss, Injury or medical condition arising from illegal, unlawful or criminal acts, any breach of the laws or regulations of the country in which the Insured Person is staying, any contravention of official government advisories, or any act committed while committing a felony, being arrested, under arrest or attempting to evade or escape arrest.

24.6. **Sports & Hazardous Activities**

24.6.1. All Expenses incurred in respect of participation in sports on a professional basis, as part of a sports studies programme, or as part of professional sporting competitions.

24.6.2. All Expenses incurred in respect of participation in the following sports or activities:
- Mountain sports: mountaineering, rock climbing (except on artificial walls with appropriate safety measures), bouldering, hiking above 3,000 metres, ski jumping, bobsleigh, skeleton, canyoning, rafting, skiing (alpine, cross-country or snowboarding) outside designated, open and marked trails;
- Aerial sports: aerobatics, gliding, parachuting, microlight flying, hang-gliding, paragliding, sky surfing, hot air ballooning;
- Water sports: diving in excess of 12 metres below the surface of the water, hydrospeed, kitesurfing, jet skiing;
- Combat and self-defence sports;
- Motor sports: driving or riding cars, motorbikes, karts or quad bikes;
- Other activities: hunting.

However, participation in the sports listed above for leisure, initiation or "discovery" purposes is covered, provided such participation is supervised by a professional duly certified by the relevant State authorities.

24.6.3. All Expenses incurred in respect of participation in extreme sports, even when practised for leisure or on an introductory basis, including but not limited to: bungee jumping, potholing, extreme canoeing or kayaking (on rivers of class above V), scuba diving more than two nautical miles from the coast, sailing (transoceanic or solo navigation more than 20 nautical miles from shelter), and base jumping.

24.7. **Comfort, Cosmetic, Alternative & Preventive Care**
Non-essential, non-curative or lifestyle-related treatment and services.

24.7.1. All Expenses incurred in respect of preventive or prophylactic care, routine screening, medical check-ups, examinations, tests, medicines, treatments or services undertaken in the absence of signs, symptoms or a diagnosed medical condition, unless expressly covered under the Benefits Schedule.

24.7.2. All Expenses incurred in respect of genetic screening, genetic testing or genetic counselling, unless expressly covered under the Benefits Schedule.

24.7.3. All Expenses incurred in respect of Preventive or prophylactic treatment or Surgery, unless such treatment is expressly covered under the Benefits Schedule and provided such treatment is not available free of charge under the public healthcare system of the country in which treatment is received.t

24.7.4. All Expenses incurred in respect of allergy tests or desensitisation treatment carried out for preventive or screening purposes, or in the absence of a documented medical condition.

24.7.5. All Expenses incurred in respect of lifestyle, wellbeing or optimisation services, including counselling, coaching or interventions aimed at improving general wellbeing rather than treating a diagnosed medical condition.

24.7.6. All Expenses incurred in respect of smoking cessation programmes or interventions, including but not limited to consultations, counselling, treatments, products, therapies, medications or other services aimed at quitting smoking.

24.7.7. All Expenses incurred in respect of cosmetic, aesthetic or appearance-related treatment, procedures or Surgery, including cosmetic or preventive dermatological care, treatment for age-related skin conditions or non-pathological dermatological concerns, and any direct or indirect complications or consequences related thereto.

24.7.8. For the avoidance of doubt, Reconstructive Surgery shall only be covered where it is Medically Necessary and required as a direct result of an Accident, Illness or Disability covered under the Policy, and where such coverage is expressly provided under the Benefits Schedule.

24.7.9. All Expenses incurred in respect of investigations, treatments or preventive measures intended to relieve symptoms associated with ageing, perimenopause or menopause.

24.7.10. All Expenses incurred in respect of weight loss or weight control programmes, treatment for obesity, anti-ageing treatment, rejuvenation therapy or related products or services.

24.7.11. All Expenses incurred in respect of treatment for hair loss, alopecia, baldness or dandruff, including medicines, supplements, devices or procedures.

24.7.12. All Expenses incurred in respect of alternative, complementary or non-conventional medicine or therapy, including but not limited to acupuncture, homeopathy, naturopathy, osteopathy, chiropractic treatment, herbal medicine and similar practices, unless expressly covered under the Benefits Schedule.

24.7.13. All Expenses incurred in respect of alternative or non-evidence-based therapies, including but not limited to chelation therapy, bioresonance therapy or diagnosis, and colonic hydrotherapy.

24.8. **Pharmaceuticals & Vaccinations**

24.8.1. All Expenses incurred in respect of medicines, drugs or pharmaceutical products which are not prescribed by a duly qualified and licensed Physician, or which are taken in excess of prescribed quantities or duration.

24.8.2. All Expenses incurred in respect of non-prescription pharmacy items, including pharmaceutical Expenses, cosmetics, hygiene products, sunscreens and/or moisturisers, make-up, comfort care products, vitamins and minerals (except for iron, folic acid and vitamin D, when prescribed by a Physician in the event of a medically proven deficiency), probiotics, food supplements, dietetic products, baby foods and mineral water, unless expressly covered under the Benefits Schedule.

24.8.3. All Expenses incurred in respect of vaccinations or immunisations, unless expressly covered under the Benefits Schedule.

24.9. **Medical Appliances, Prostheses & Mobility Aids**
Unless expressly covered under the Benefits Schedule.

24.9.1. All Expenses incurred in respect of the purchase or rental of medical appliances, devices or durable medical equipment, including but not limited to prostheses, corrective devices, thermometers, blood pressure monitors or similar equipment.

24.9.2. All Expenses incurred in respect of external prostheses, unless such prosthesis is required as a direct result of a Disability first occurring during the Period of Insurance and is expressly covered under the Benefits Schedule.

24.9.3. All Expenses incurred in respect of mobility aids, including but not limited to wheelchairs, walking aids, crutches or similar devices.

24.9.4. All Expenses incurred in respect of hearing aids, hearing devices or related accessories.

24.10. **Dental & Optical**

24.10.1. All Expenses incurred in respect of dental services, including examinations, treatment, procedures, prostheses, appliances and related materials or services, unless expressly covered under the Benefits Schedule.

24.10.2. All Expenses incurred in respect of mouth guards, occlusal splints or similar protective dental devices, unless expressly covered under the Benefits Schedule.

24.10.3. Dental examination or treatment carried out for cosmetic or decorative purposes only, including Dental Treatment involving the use of precious stones or decorative materials, unless expressly covered under the Benefits Schedule.

24.10.4. All Expenses incurred in respect of Orthodontic Treatment, including braces, aligners or related appliances, where such treatment is initiated on or after the Insured Person's 16th birthday, unless expressly covered under the Benefits Schedule.

24.10.5. All Expenses incurred in respect of Dental Treatment, services or procedures, unless such treatment is required to repair or restore damage to sound natural teeth following an Accident occurring during the Period of Insurance and within the timeframe specified in the Benefits Schedule. For the avoidance of doubt, Dental Treatment required directly or indirectly as a result of biting, chewing or teeth grinding is not covered.

24.10.6. All Expenses incurred in respect of vision tests, eye examinations or visual aids intended to correct vision, including spectacles, frames, lenses and contact lenses, unless prescribed by an ophthalmologist or optician and expressly covered under the Benefits Schedule.

24.10.7. All Expenses incurred in respect of contact lenses without visual correction.

24.10.8. All Expenses incurred in respect of sunglasses, whether prescription or non-prescription, including any related lenses, frames or accessories.

24.10.9. All Expenses incurred in respect of refractive eye surgery or procedures intended to correct vision, including but not limited to LASIK, PRK or similar techniques, unless expressly covered under the Benefits Schedule.

24.11. **Maternity, Fertility & Family planning**
Applies unless expressly covered under the Benefits Schedule.

24.11.1. All Expenses incurred in respect of termination of pregnancy or abortion, except where there is an immediate threat to the life of the mother, as certified by a duly qualified medical practitioner.

24.11.2. All Expenses incurred in respect of pregnancy, childbirth, miscarriage, antenatal, perinatal or postnatal care, and any complications or consequences thereof. Coverage for Complications of Pregnancy shall be subject to the specific Complications of Pregnancy limit stated in the Benefits Schedule.

24.11.3. All Expenses incurred in respect of non-Medically Necessary ultrasound scans during pregnancy, including but not limited to 3D, 4D or similar scans.

24.11.4. All Expenses incurred in respect of elective caesarean section deliveries performed prior to the 38th week of gestation.

24.11.5.	All Expenses incurred in respect of surgical or invasive medical procedures performed on a foetus prior to birth.
24.11.6.	All Expenses incurred in respect of Assisted Conception or Fertility Treatment, and any Complications of Pregnancy arising therefrom.
24.11.7.	All Expenses incurred in respect of fertility or infertility-related investigations or treatments, including but not limited to fertility preservation, assisted reproduction techniques, donor services, reversal of sterilisation, investigational techniques, or the storage of reproductive materials, unless expressly covered under the Fertility Treatment benefit.
24.11.8.	All Expenses incurred in respect of varicocele or varicocelectomy.
24.11.9.	All Expenses incurred in respect of surrogacy arrangements, including treatment, services or care provided to or for a surrogate mother or intended parents.
24.11.10.	All Expenses incurred in respect of voluntary sterilisation procedures, including tubal ligation or vasectomy, and any related treatment or complications.
24.11.11.	All Expenses incurred in respect of contraception and related services or products, including contraceptive devices, medicines, implants, injections or procedures, unless expressly covered under the Contraceptive Services benefit.
24.12.	**Congenital, Hereditary & Genetic Conditions**
24.12.1.	All Expenses incurred in respect of congenital, hereditary or genetic conditions or Illnesses, whether diagnosed at birth or at any time thereafter, unless expressly covered under the Benefits Schedule. Where Neonatal Disability is expressly covered under the Benefits Schedule, such coverage shall apply notwithstanding this exclusion.
24.13.	**Mental Health, Neurological & Sleep Conditions** Applies unless expressly covered under the Benefits Schedule.
24.13.1.	All Expenses incurred in respect of mental, psychiatric, psychological or nervous conditions, as well as any treatment, services, therapies or medicines provided for the management or treatment of such conditions.
24.13.2.	All Expenses incurred in respect of developmental, behavioural or neurodevelopmental disorders, including developmental delay, learning Disabilities, attention deficit disorders, autism spectrum disorders or similar conditions.
24.13.3.	All Expenses incurred in respect of sleep disorders, including but not limited to insomnia, sleep-related breathing disorders, hypersomnia or parasomnias, and any medicines, treatments or services prescribed solely for the management or treatment of such sleep disorders.
24.14.	**Sexual Health, STDs & Hormonal Treatment**
24.14.1.	All Expenses incurred in respect of treatment for sexual dysfunction or sexual performance disorders, including erectile dysfunction, impotence, loss of libido or similar conditions, whatever the cause.
24.14.2.	All Expenses incurred in respect of treatment, care or tests directly or indirectly related to sexually transmitted diseases or infections.
24.14.3.	All Expenses incurred in respect of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or any Illness or condition arising therefrom, unless expressly covered under the HIV/AIDS benefit.
24.14.4.	All Expenses incurred in respect of growth hormone treatment or therapy.
24.14.5.	All Expenses incurred in respect of hormone replacement therapy or hormonal treatment, unless such treatment is Medically Necessary and expressly covered under the Hormone Replacement Therapy benefit.
24.14.6.	All Expenses incurred in respect of gender reassignment, gender affirmation or gender identity-related treatment, including Surgery, hormone therapy or related services, unless expressly covered under the Gender Affirmation Surgery benefit.
24.14.7.	All Expenses incurred in respect of treatment, medicines or therapies intended to enhance sexual, emotional or cognitive performance, where such treatment is not Medically Necessary.
24.15.	**Long-term, Custodial & Non-Medical Care**
24.15.1.	All Expenses incurred in respect of stays in long-term, social or Custodial care institutions, including but not limited to geriatric institutions, medico-educational facilities, facilities for dependent elderly persons, rest homes, convalescent homes, preventoria, unauthorised sanatoriums or similar establishments.
24.15.2.	All Expenses incurred in respect of nursing care provided at home or elsewhere for domestic, Custodial or social reasons and not medically required.
24.15.3.	All Expenses incurred in respect of services or treatment provided while the Insured Person is a bed patient in any facility that is not a Hospital, including intermediate care facilities, Nursing Homes or similar institutions.
24.15.4.	House calls, delivery of medicines or other items, or services rendered at a person's home, office, hotel room or similar place for non-medical purposes.
24.15.5.	All Expenses incurred in respect of Custodial care, Maintenance Care or rest cures.

24.16. **Organ Transplants, Stem Cells & Biological Materials**
Unless expressly covered under the Benefits Schedule.

24.16.1. All Expenses incurred in respect of organ, tissue or cell transplantation, including but not limited to heart, lung, liver, kidney, pancreas, bone marrow or other human tissue transplants.

24.16.2. All Expenses incurred in respect of Stem Cell Treatment, transplantation or harvesting, unless such treatment is expressly covered under the Benefits Schedule. This exclusion includes the harvesting, collection or storage of stem cells for future or unplanned use.

24.16.3. All Expenses incurred in respect of costs charged to an organ, tissue or cell donor, including medical treatment, investigations, Hospitalisation or related services provided to the donor.

24.16.4. All Expenses incurred in respect of donor search, procurement, transport or logistical costs associated with organ, tissue or cell transplantation.

24.16.5. All Expenses incurred in respect of the storage, preservation or banking of organs, tissues, cells or other biological material.

24.17. **Transport, Driving & Medical Travel Exclusions**

24.17.1. All Expenses incurred in respect of loss, Injury or Illness arising while boarding, disembarking from or travelling as a passenger in any aircraft which is not licensed to carry passengers for reward and does not operate as a commercial airline.

24.17.2. All Expenses incurred in respect of loss, Injury or Illness arising from intentional road traffic Accidents or from the use of a vehicle in breach of applicable laws or regulations.

24.17.3. All Expenses incurred in respect of loss, Injury or Illness arising while driving or riding any motor vehicle or motorcycle without a valid driving licence or, where applicable, without wearing legally required safety equipment, including helmets, in accordance with local regulations.

24.17.4. All Expenses incurred in respect of travel or transportation undertaken for the purpose of obtaining medical treatment, including associated transportation costs, unless such travel forms part of an Emergency Medical Evacuation approved in advance or arranged by the Emergency Assistance Provider, or is expressly covered under the Benefits Schedule.

DEFINITIONS

Unless otherwise stated, the following definitions apply throughout this Policy, including the Benefits Schedule, Terms and Conditions and any endorsements. Words in the singular include the plural and vice versa.

A. **ACCIDENT OR ACCIDENTAL:** A sudden, unexpected, and specific event, external to the body, beyond one's control, and directly leading to physical Injury, which occurs at an identifiable time and place.

A. **ADVANCED MEDICAL IMAGING:** Diagnostic imaging techniques including Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans and Positron Emission Tomography (PET) scans.

A. **ADVANCED THERAPY MEDICINAL PRODUCTS (ATMPS):** Medicines for human use that are based on genes, tissues, or cells, including but not limited to: Gene therapy medicinal products; Somatic cell therapy medicinal products; Tissue-engineered products; Combined ATMPs (for example, therapies integrated with a medical device). ATMPs are subject to specific regulatory approval and clinical governance requirements. ATMPs are payable only where expressly covered under the ATMP benefit and subject to its specific limit.

A. **ACTIVE CANCER TREATMENT:** A course of treatment intended to affect the growth of the cancer by shrinking the cancer, stabilising it or slowing the spread of disease, and not given solely to relieve symptoms or to prevent a recurrence. It also includes the first consultation with the oncologist following completion of the last planned course of Active Cancer Treatment, and associated diagnostic scans and tests.

A. **ALCOHOL AND SUBSTANCE ABUSE:** This benefit provides coverage for the diagnosis and treatment of alcohol or substance abuse disorders when clinically appropriate and recommended by a licensed medical practitioner. Covered services may include:

- Medically supervised detoxification
- Inpatient rehabilitation at a licensed facility
- Outpatient counselling or therapy (individual, group, or family)
- Medication-assisted treatment (e.g. for opioid or alcohol dependence)
- Psychiatric or psychological assessment related to substance abuse

The coverage is subject to a diagnosis by a licensed medical practitioner, a Pre-authorisation by us and that the treatment is delivered by accredited professionals or licensed facilities. Expenses for Alcohol and Substance Abuse treatment may only be claimed under the Alcohol and Substance Abuse section of the benefits schedule, and no other type of benefit under this policy provides coverage in connection with Alcohol and Substance Abuse.

A. **ALTERNATIVE MEDICINE:** Medical practices and treatments that are not considered part of conventional Western medicine, and which are provided by practitioners listed in the Benefits Schedule.

A. **AMBULANCE:** Transportation within the same country by a licensed emergency or medical transport service to or from a Hospital.

A. **ARTIFICIAL LIFE MAINTENANCE:** Medical treatment or interventions that artificially sustain or replace vital bodily functions, including but not limited to mechanical ventilation, circulatory support, or other life-support systems, where the patient is unable to maintain such functions independently.

A. **ASSISTED CONCEPTION**: The use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to Intra-uterine insemination (IUI), In vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI), or the use of any form of treatment to induce or increase ovulation.

B. **BEHAVIOURAL OR DEVELOPMENTAL DISORDER:** A Disability classified in categories F53 and F59 to F98 of the International Classification of Diseases 10th Revision (2025 version).

B. **BENEFITS SCHEDULE:** The schedule(s) showing each of the benefits available under this policy and the limit available for those benefits.

C. **CASH BENEFIT:** A fixed cash amount payable per day or per event, irrespective of actual medical Expenses incurred.

C. **CHRONIC CONDITION:** A disease, Illness or Injury that has one or more of the following characteristics:
- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests; or
- it needs ongoing or long-term control or relief of symptoms; or
- You need to be rehabilitated or specially trained to cope with it; or
- it continues indefinitely; or
- it has no known cure; or
- it comes back or is likely to come back.

C. **CLAIM:** A request made by or on behalf of an Insured Person for payment or reimbursement of benefits under this Policy.

C. **CLINIC:** Any medical centre which provides medical services without any overnight patients and which holds a license or is registered as a "Clinic" under the law in the locality where services are provided.

C. **CO-INSURANCE PERCENTAGE:** The share of Expenses for which You are liable, shown on the Benefits Schedule.

C. **COMPLICATIONS OF CHILDBIRTH:** Any complications that arise during the delivery stage including emergency C-section. The coverage of the complication of childbirth is applicable to the mother and child.

C. **COMPLICATIONS OF PREGNANCY:** Only the complications that arise during the antenatal stage of pregnancy are covered. Any Claims related to wholly or partially or arising directly or indirectly during the delivery stage, including complications arising from the delivery stage, shall not be covered. The coverage of the complication of pregnancy is applicable to the mother only.

C. **COMPLEMENTARY THERAPIES:** Therapeutic services rendered by one of the types of practitioner listed in the Complementary Medicine and Traditional Chinese Medicine section of the Benefits Schedule, other than yourself or someone related to You by blood, marriage or adoption, who is qualified by education and training and, if required or permitted to be licensed or registered by the laws of the place where service took place, is licensed or registered in that place, and who in performing such services is acting within the scope and training of that discipline.

C. **CONGENITAL CONDITION:** Any condition classified as a congenital anomaly in the International Classification of Diseases 10th Revision (2025 version).

C. **CONTINUOUS PERSONAL MEDICAL EXCLUSIONS:** Means that We apply the special underwriting terms of a Preceding Policy. Any Pre-existing Condition which would have been covered by the Preceding Policy shall continue to be covered under this Policy, but not to exceed the limits which would have been obtainable under the provisions of the Preceding Policy or the provisions of this Policy, whichever is lower.

C. **CONTRACEPTIVE SERVICES**: This benefit includes consultations and services related to contraception, including:
- Medical consultation and counselling on contraceptive options;
- Prescription and insertion of approved contraceptive methods such as: Oral contraceptives (birth control pills), Injectable or implantable contraceptives, Intrauterine devices (IUDs/sterilets), Removal, or replacement of contraceptive devices, when appropriate;
- The cost of the contraceptive item or device itself.

Services must be provided or prescribed by a licensed medical practitioner.

C. **COUNSELLOR:** A qualified and licensed mental health professional who provides counselling services within the scope of their recognised training and accreditation, excluding psychologists and psychiatrists unless otherwise stated in the Benefits Schedule.

C. **COSMETIC TREATMENT:** Surgery, chemical treatment, or other procedures performed to reshape or modify structures of the body or physical appearance, including treatment of any medical condition which arises in any way from cosmetic procedures.

C. **COUNTRY OF RESIDENCE:** The geographical country in which the Policyholder or Insured Person, as the case may be, spends the greatest amount of time during the Period of Insurance.

C. **CUSTODIAL OR MAINTENANCE CARE:** Care provided mainly:
- for personal needs, comfort or convenience for which specialised medical training or skills are not necessary; or
- to maintain, rather than improve, a physical or mental function, or to provide a protected environment, including Physician-prescribed bed rest.

D. **DAY-PATIENT:** A patient who is admitted to a Hospital, Clinic or medical facility for treatment and discharged on the same day, without occupying a hospital bed overnight.

D. **DEDUCTIBLE:** An amount shown on the Benefits Schedule corresponding to a benefit available under this policy. We are entitled to deduct this amount from any payment of Expenses.

D. **DENTAL TREATMENT:** Evaluation, diagnosis, prevention, and surgical or non-surgical treatment of diseases, disorders and conditions of the oral cavity, maxillofacial area, and the adjacent and associated structures.

D. **DENTIST:** A properly qualified practitioner other than yourself or someone related to You by blood, marriage or adoption, who is licensed by the competent authorities of the country in which treatment is provided to render Dental Treatment, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

D. **DEPENDANT:** Your spouse under the law of your Country of Residence or your de facto partner. Each of your unmarried children, stepchildren or adopted children who are under twenty-three (23) years of age for all or part of the Period of Insurance.

D. **DIAGNOSTIC SCANS AND TESTS:** Medically necessary tests prescribed by a Physician to investigate the cause and nature of symptoms of a Disability. Limited to laboratory tests and pathology, ultrasound, ECG, X-ray, and endoscopic examinations not classified as Invasive Endoscopic Examinations.

D. **DISABILITY:** An Illness or Injury, and any symptoms, sequelae, or complications thereof. In the case of Injury, it means all injuries arising from the same event or series of contiguous events.

E. **EFFECTIVE DATE:** The date specified in the policy pack as the date on which the Period of Insurance in respect of any Insured Person commences under this policy.

E. **ELIGIBLE EMPLOYEE:** A full-time employee of the Policyholder who has a staff grade as listed in the policy endorsement or as agreed separately between us and the Policyholder.

E. **EMERGENCY:** A sudden change in your health as a result of an Accident or acute exacerbation of a Disability which requires immediate medical or surgical intervention within 24 hours to avoid permanent damage to your life or health.

E. **EMERGENCY ROOM (ER) TREATMENT:** Medical treatment received in a hospital emergency department as a result of an Injury within 48 hours of an Accident, or an acute and unexpected exacerbation of a medical condition requiring urgent medical or surgical intervention to avoid permanent damage to life or health.

E. **EXPENSES:** Amounts You incur during the Period of Insurance for a Medically Necessary service, and which fall within the categories of benefits shown on the Benefits Schedule.

E. **EXPERIMENTAL TREATMENT:** Treatment and drugs are deemed experimental if they have not been approved by the European Medicines Agency (EMA), and the Food and Drug Administration (FDA) despite the treatment is approved by the local governance. Approved treatment and drugs should be used within the terms of a valid license; it means that off-label drug will be considered as experimental.
Surgery, procedures are deemed experimental if they have not been recommended by international clinical guidelines and used within their indication. Clinical consensus is not considered as an international clinical guideline.
Should these agencies or guidelines have conflicting views or provide no guidance, APRIL medical team will make a decision based on published medical articles which are using a rigorous scientific method (including randomised controlled trial) to prove the safety and efficacy of the treatment and drug. This definition also includes medical equipment, technique or approach used for purposes other than those defined under their license or which is undergoing study, research, or testing.

E. **EXTERNAL PROSTHESIS:** An artificial body part prescribed by a Physician as part of treatment relating to a Disability covered by this policy.

F. **FERTILITY TREATMENT:** Medical evaluation and treatment intended to assist an individual or couple in achieving pregnancy following a diagnosis of infertility. Coverage may include:
- Diagnostic testing and laboratory investigations;
- Fertility medications prescribed by a medical specialist;
- Ovulation induction;
- Intrauterine insemination (IUI);
- In vitro fertilisation (IVF);
- Embryologist services related to covered procedures.

Coverage applies only when:
- A confirmed diagnosis of infertility has been made by a licensed specialist; and
- The procedures are medically recognized and approved for use.

F. **FOLLOW UP CANCER CARE:** Specialist consultations, laboratory tests and pathology, CT scans, PET Scans, MRIs, ultrasounds, endoscopic exams, and x-rays ordered by a specialist with the aim of detecting the existence of newly formed or previously un-detected cancer cells, and Medicines and Drugs given to prevent recurrence of cancer. Follow Up Cancer Care does not include Active Cancer Treatment.

F. **FULL MEDICAL UNDERWRITING:** means that You provide us with a detailed medical history on the Full Medical Underwriting Application Form to enable us to decide whether to accept or decline your application and whether We need to apply any specific exclusions or loadings to your policy.

G. **GENDER AFFIRMATION SURGERY:** refers to a set of surgical procedures aimed at aligning an individual's physical characteristics with their gender identity. Coverage is subject to medical necessity and Pre-authorisation, and may include but it is not limited to:
- Chest surgery (e.g. mastectomy or breast augmentation);
- Genital reconstruction surgery (e.g. vaginoplasty, phalloplasty, metoidioplasty);
- Orchiectomy, hysterectomy, salpingo-oophorectomy;
- Urethroplasty, penectomy, labiaplasty, vulvoplasty, clitoroplasty;
- Repair of introitus, penile skin inversion, urethral lengthening, or rerouting;
- Construction of vagina with graft or coloproctostomy (where applicable);
- Other Medically Necessary procedures recommended under the standards of care defined by the World Professional Association for Transgender Health (WPATH).

Coverage is payable when all of the following are met:
- A formal diagnosis of gender dysphoria is made by a qualified healthcare provider; and
- The insured has completed appropriate psychological evaluation or counselling (as applicable); and
- Any hormonal therapy protocols required have been initiated, unless contraindicated; and
- Pre-authorization has been granted by the insurer prior to any surgical procedure.

Expenses for Gender Affirmation Surgery may only be claimed under the Gender Affirmation Surgery section of the benefits schedule, and no other type of benefit under this policy provides coverage in connection with Gender Affirmation Surgery.

H. **HEREDITARY CONDITIONS:** An Illness caused by a genetic abnormality passed down from the parents' genes. Cancers that are present in combination with other symptoms of the Hereditary Condition are included in this definition.

H. **HIV/AIDS:** Infection with the Human Immunodeficiency Virus and any mutation thereof and/or Acquired Immune Deficiency Syndrome ("AIDS") and any symptoms relating thereto or Illnesses arising therefrom. AIDS includes any cancer or infection in an HIV-infected person who, on or at any time before the date of service, had a CD4 T-cell count below 200 cells per microliter. HIV/AIDS costs may only be claimed under the HIV/AIDS section of the Benefits Schedule, and no other type of benefit under this policy provides coverage in connection with HIV/AIDS.

H. **HOME COUNTRY:** The country of the passport or identity document of Insured Persons listed on the application or notified to us under the terms governing material changes. For any Dependent who does not hold a passport, it will be the Home Country of their Policyholder.

H. **HOME HOSPITALISATION / NURSING AT HOME:** Hospital-level nursing care provided at home when prescribed by a Physician, as an alternative to Inpatient treatment.

H. **HORMONE REPLACEMENT THERAPY:** Medically prescribed hormone therapy for the treatment of a diagnosed medical condition, excluding hormone therapy related to natural ageing, menopause or gender transition unless otherwise stated in the Benefits Schedule.

H. **HOSPICE OR PALLIATIVE TREATMENT:** A program of medical, psychological, social, and spiritual care provided to persons who have been diagnosed as suffering from a Terminal Illness. Treatment must be prescribed by a Physician and provided by a Hospital or institution licensed by the competent medical authorities of the country in which care is provided and which, in providing care, is practicing within the scope of its license. Expenses for Hospice or Palliative Treatment may only be claimed under the Hospice or Palliative Treatment section of the Benefits Schedule and shall not be payable under other benefits.

H. **HOSPITAL:** An institution licensed by the competent medical authorities of the country in which it is located to provide care and treatment of sick and injured persons as bed patients and which:

- has full diagnostic, therapeutic and surgical procedures; and
- provides 24 hour a day nursing services by registered graduate nurses; and is supervised by a staff of Physicians; and
- Is not primarily a Clinic, an intermediate care facility or Nursing Home, a mental institution, a home for the aged, or a place for alcoholics or drug addicts.

H. **HOSPITAL ROOM AND BOARD:** Accommodation in a hospital room and the provision of standard hospital meals during an Inpatient admission, subject to the room category shown in the Benefits Schedule.

SINGLE OCCUPANCY ROOM – The base class of rooms having one (1) patient bed per room with an en-suite bath or shower room. Single occupancy room does not include higher-tier accommodations and luxury rooms such as suites, VIP rooms, or deluxe rooms.

DOUBLE OCCUPANCY ROOM – A class of room having two (2) patient beds per room and shared bath or shower room, whether both beds are occupied or not.

WARD – A class of room having three (3) or more patient beds per room, whether all beds are occupied or not.

Room Category Coverage and Penalties: If a member is admitted to a higher category room than entitled to, a 50% co-payment penalty will be applied. In Hong Kong and Singapore, this penalty will be applied to the entire hospital bill.

In other countries, the 50% penalty will be applied to all items impacted by the room type selected. This approach accounts for regional variations in healthcare practices and costs.

H. **HOSPITAL TREATMENT:** Medical treatment received as an Inpatient or Day-patient in a Hospital.

H. **HOSPITALISATION:** Admission as an Inpatient to a Hospital.

H. **HYPNOSIS:** also referred to as guided hypnosis, is a form of psychotherapy that uses relaxation, extreme concentration, and intense attention to achieve a heightened state of consciousness or mindfulness.

H. **HYPNOTHERAPIST:** Qualified Hypnotherapists and Psychologists can administer hypnosis to individuals.

I. **ILLNESS:** A physical condition, including symptoms, sequelae, or complications, marked by a pathological deviation from the normal healthy state during the Period of Insurance.

I. **INJURY:** Identifiable physical damage to your body which is caused by an Accident solely and independently of any other causes, is not intentionally self-inflicted, and does not result from Illness.

I. **INPATIENT:** A patient who is admitted to a Hospital or medical facility and occupies a hospital bed overnight or longer.

I. **INTENSIVE CARE UNIT:** A class of room dedicated to the constant, close monitoring of the vital body functions of critically ill patients, which provides a high ratio of nursing staff to patients, and which has full facilities for the resuscitation of patients. This definition also includes a coronary care unit which has facilities not less comprehensive than those described above.

I. **INTERMEDIARY:** The authorised agent, broker or financial advisor who arranged this cover.

I. **INTERMEDIATE CARE FACILITY OR NURSING HOME:** A place devoted to providing support services for individuals requiring medical, nursing, or Custodial or Maintenance Care in a residential setting.

I. **INSURED PERSON:** The person/persons identified in the policy pack.

I. **INVASIVE ENDOSCOPIC EXAMINATION:** The following endoscopies: arthroscopy, colonoscopy, cystoscopy, enteroscopy, laparoscopy, mediastinoscopy, sigmoidoscopy, thoracoscopy/pleuroscopy, upper gastrointestinal endoscopy, ureteroscopy.

K. **KIDNEY DIALYSIS:** Haemodialysis and peritoneal dialysis. Kidney dialysis Expenses may only be claimed under the Kidney Dialysis section of the Benefits Schedule, and no other type of benefit under this policy provides coverage in connection with Kidney Dialysis.

M. **MAJOR ASSISTED CONCEPTION:** The use of surgical methods to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to Intra-uterine insemination (IUI), In vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI).

M. **MAJOR DENTAL TREATMENT:** Dental treatment involving advanced, surgical, or complex procedures, including but not limited to:

- surgical removal of impacted, buried, or unerupted teeth, roots, or odontomes;
- treatment of disorders of the temporomandibular joint (TMJ);
- Orthodontic Treatment commenced below the age of 16;
- dental implants;
- endodontic treatments such as root canal therapy or apicoectomy;
- dentures (new or repair of existing);
- crowns and bridges made of gold, amalgam, composite, or porcelain;
- periodontal treatments including deep oral prophylaxis or root planing;
- treatment by a Dentist of Illnesses of the oral mucosa and directly related laboratory tests or pathology services;
- antibiotics or medicines for pain management prescribed by a Dentist in connection with covered Major Dental Treatment.

M. **MEDICAL APPLIANCES:** The following items and their accessories if prescribed by a Physician for a Disability: cranial helmets, nebulisers, oxygen pumps and masks, hearing aids, corrective splints, slings, insulin pumps, infusion pumps, glucose monitors and lancets, orthotics/orthopaedic braces, supports (addition) and boots; tracheoesophageal voice prosthesis, compression stockings, arch support, and consumable diabetes or ostomy supplies.

M. **MEDICAL CHECK-UP:** Consultations and tests that are undertaken without any clinical signs or symptoms being present.

M. **MEDICALLY NECESSARY:** Possessing an identifiable relationship to either a covered Disability or symptom(s) of a Disability which if existing would be covered under the policy. It refers to necessary and appropriate medical treatment, services, or supplies, i.e.:

- a therapeutic service required to treat or prevent damage to life or health where You have an Illness or Injury;
- a diagnostic service to determine whether therapeutic services are necessary, where You have active symptoms, the cause of which are unknown, but which are suggestive of an Illness or Injury, or
- A treatment or service required for reasons other than the comfort or convenience of You or Physicians.

The term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. It also includes the appropriateness of the type of service (Outpatient/Day-patient/Inpatient) based on the medical standard. When specifically applied to Inpatient request, We reserve the right to decline an Inpatient stay for a procedure or treatment that is commonly prescribed as Outpatient/Day-patient.

M. **MEDICINES AND DRUGS:** Medicines and pharmaceutical products for which a Physician's Prescription is required for purchase, and which have been dispensed by a Physician's office or a licensed pharmacist after having been prescribed by a Physician.
This includes associated medical consumables, such as dressings and bandages, and Medically Necessary administration services, including injections or wound care performed by a qualified nurse or pharmacist, when directly related to the prescribed treatment.

M. **MENTAL AND NERVOUS CONDITION:** Any condition classified in categories F01 – F09, F20 – F48, F54 and F99 of the International Classification of Diseases 10th Revision (2025 version).

M. **MINOR ASSISTED CONCEPTION:** The use of oral or injected medication to induce or regularise the menstrual cycle in order to increase the chance of conception.

M. **MINOR/ROUTINE DENTAL TREATMENT:** Dental check-up, x-ray, gold, or amalgam or composite or porcelain inlays/onlays/fillings; routine tooth cleaning, scaling, and prophylaxis (including when done by an Oral Hygienist); simple extractions; mouth guard; and application of sealants.

M. **MOBILITY AIDS:** Crutches, canes, walkers, manual wheelchairs, and non-motorised knee scooters.

N. **NEONATAL DISABILITY:** A Disability which existed during the neonatal period, and any Disabilities directly or indirectly arising therefrom or relating thereto. It includes pre-term birth and any Congenital Conditions which are diagnosed or present symptoms of which medical professionals or parents are aware or reasonably should be aware of during the neonatal period.

N. **NEONATAL PERIOD:** The period between birth and either the 28th day of life or the 15th day after discharge from Hospital (dates inclusive), whichever is later.

N. **NEWBORN INFANT:** A child under 28 days of age.

N. **NON-PRESCRIPTION PHARMACY ITEMS:** Pharmacy products that do not require a Physician's Prescription and are purchased from a licensed pharmacy, limited to items specifically listed in the Benefits Schedule, such as:

- vitamins and mineral supplements;
- smoking cessation products;
- medically indicated topical treatments.

This does not include food or beverages, cosmetics, toiletries, personal care products, infant products, herbal or dietary supplements sold as food, or any non-medical retail items.

N. **NURSERY CARE :** includes (i) accommodation for the child, (ii) customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures (these essential examinations are carried out immediately following birth) and, (iii) further preventive diagnostic procedures, such as routine swabs, blood typing, and hearing tests, if they occur before the child's discharge and if they are performed within 7 days from the childbirth.

O. **OBESITY (BARIATRIC) SURGERY:** Obesity surgery (also called bariatric surgery) refers to surgical procedures performed to treat medically significant obesity for adults if BMI>40, where weight-loss has not been achieved through non-surgical methods such as diet, exercise, nutrition programs, and medication. These surgeries aim to reduce stomach size and/or alter the digestive system to help with long-term weight loss and improve weight-related health conditions. Expenses for Obesity (Bariatric) Surgery may only be claimed under Obesity (Bariatric) Surgery section of the benefits schedule, and no other type of benefit under this policy provides coverage in connection with Obesity (Bariatric) Surgery.

O. **ORAL HYGIENIST:** A properly qualified employee of a Dentist who is licensed, if required, by the competent medical authorities of the country in which treatment is provided to render services such as cleaning and anaesthesia, and who is rendering such treatment at the direction of, and under the direct supervision of a Dentist.

O. **ORGAN TRANSPLANTATION:** Transplantation of a cornea, kidney, heart, liver, lung, or bone marrow from one human to another.

O. **ORTHODONTIC TREATMENT:** Dental treatment intended to correct the alignment of teeth or jaws.

O. **OUTPATIENT:** A patient who receives medical treatment without being admitted as an Inpatient or Day-patient.

O. **OUTPATIENT SURGERY:** Minor surgical procedures performed without Hospital admission and not classified as Inpatient or Day-patient treatment. This includes, but is not limited to, procedures on the skin and subcutaneous tissue, laryngoscopy, nasopharyngoscopy and otoscopy.

P. **PARENTAL ACCOMMODATION:** A fee for an additional bed in the same room for a parent or legal guardian staying with a Dependent child covered under this policy who is admitted as an Inpatient in a Hospital for the treatment of a covered Disability.

P. **PERIOD OF INSURANCE:** The period starting at 00:00 hours Qatar time on the first day shown on the policy pack and ending at 11:59 hours Qatar time on the last day shown on the policy pack. If an Insured Person has been added to the policy mid-year, it means the period shown in the policy pack in respect of that Insured Person. If this policy is renewed, the Effective Date shown in the policy pack issued at renewal will be first day of the new Period of Insurance.

P. **PHYSICIAN:** A doctor of western medicine other than yourself or someone related to You by blood, marriage or adoption, who is licensed by the competent medical authorities of the country in which treatment is provided, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

P. **PHYSIOTHERAPY:** Treatment of a Disability by physical methods such as manipulation and mobilisation, Transcutaneous Electrical Neural Stimulation, heat treatment, and exercise rather than by drugs or Surgery. Treatment must be performed by a Physiotherapist, other than yourself or someone related to You by blood, marriage or adoption, acting within the scope and training of the Physiotherapy discipline and who, if required or permitted to be licensed or registered by the laws of the place where service took place, is licensed or registered in that place.

P. **POLICYHOLDER:** An individual or organization that enters into an insurance contract with the insurer and pays the insurance premium. The Policyholder has an insurable interest in the Insured Person. The Policyholder may also be the Insured Person or the beneficiary.

P. **POST-HOSPITALISATION TREATMENT:** Medical treatment received on an Outpatient basis following discharge from a covered Hospitalisation, when prescribed by a Physician and directly related to the condition treated during the Hospitalisation. Post-Hospitalisation treatment includes Physician consultations, Diagnostic Scans and Tests, medicines, drugs and dressings, and Outpatient Physiotherapy.

P. **PRE-AUTHORISATION:** Means the determination by us that a service is Medically Necessary and appropriate, including consideration of the need for the proposed level of care and the availability of alternatives.

P. **PRECEDING POLICY:** Means a long-term international health insurance policy covering Illness and bodily Injury which terminates no earlier than the day immediately preceding the date on which the Insured Person becomes entitled to benefits under this Policy, and a copy of which has been provided to Us at the time of application. It must be of an equivalent class of cover to that being applied for and meet the acceptability criteria determined by Us, at the time of application.

P. **PRE-EXISTING CONDITION:** Any Disability:

- which existed before the Period of Insurance and which presented signs or symptoms of which You were aware or should reasonably have been aware of; or
- for which You have sought or received treatment, medication, advice, or diagnosis in the 24 months before the Period of Insurance; or
- which You knew to exist before the Period of Insurance and whether or not You sought or received treatment, medication, advice, or diagnosis for it.

P. **PRE-HOSPITALISATION TREATMENT:** Medical treatment received on an Outpatient basis prior to admission for a covered Hospitalisation, when prescribed by a Physician and directly related to the condition requiring the Hospitalisation. Pre-Hospitalisation treatment includes Physician consultations, Diagnostic Scans and Tests, medicines, drugs, and dressings.

P. **PRE-TERM BIRTH:** Birth of a living child before 37 weeks of pregnancy are completed.

P. **PREVENTIVE (PROPHYLACTIC) SURGERY:** refers to surgical procedures performed to remove tissues, organs, or glands that have a high probability of becoming cancerous in the future, aimed at reducing the risk of future health issues. This includes, but is not limited to, procedures such as mastectomy or prophylactic oophorectomy when a parent, grandparent, sibling, or child has been diagnosed with a disease that is part of a hereditary cancer syndrome (such as breast cancer or ovarian cancer) confirmed by a genetic test. The Surgery should be prescribed by a qualified medical professional and approved as Medically Necessary by our Medical Team or a qualified Physician approved by us. Expenses for Preventive (Prophylactic) Surgery may only be claimed under the Preventive (Prophylactic) Surgery section of the benefits schedule, and no other type of benefit under this policy provides coverage in connection with Preventive (Prophylactic) Surgery.

P. **PREVENTIVE CARE / TREATMENT:** Treatments that prevent occurrence or recurrence of a Disability, Injury, or Illness, rather than treating a Disability.

P. **PROFESSIONAL FEES:** Surgeon's fees, anaesthetist fees, dietician fees, general nursing fees, Physiotherapist fees, speech therapist fees, and Physician fees.

P. **PSYCHOLOGIST OR PSYCHOTHERAPIST** : A psychologist / psychotherapist other than yourself or someone related to You by blood, marriage or adoption, who is licensed by the competent medical authorities of the country in which treatment is provided or in which the psychologist / psychotherapist finished the study, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

R. **REASONABLE AND CUSTOMARY:** An amount comparable to that charged by others of similar professional standing in the same locality, for the same class of hospital room, for a person of similar sex and age, for a similar Disability, without regard to ability to pay or the availability or adequacy of insurance. Where an Insured Person stays in a hospital room above the hospital room and board level shown on the Benefits Schedule, Reasonable and Customary charges will be limited to comparable charges for the highest class of room for which the Insured Person is covered.

R. **RECONSTRUCTIVE SURGERY:** Surgery performed to improve the function or appearance of abnormal structures of the body caused by a Disability.

R. **REFERRAL / PRESCRIPTION:** A dated, written or electronic instruction issued by a Physician prior to the commencement of treatment, identifying the Insured Person, the Disability to be treated, and the medical reason for the treatment, service, medicine, drug, device, or supply prescribed.

R. **REHABILITATION CENTRE:** A facility specifically licensed to care for people who have suffered neurological, musculoskeletal, orthopaedic and other serious medical conditions and are not yet able to care for themselves at home. It must be:

- a unit within a Hospital or a separate facility having accommodation for bed patients;
- organised to provide an intensive rehabilitation program to inpatients;
- under supervision of a Physician; and
- staffed full-time by nurses working under the supervision of a registered nurse.

R. **REHABILITATION TREATMENT:** Treatment received as an Inpatient or Day-patient following a covered Hospitalisation, upon Referral by a specialist to restore normal form/near to normal form or function to the body. In addition to room and board and general nursing fees, the following additional costs incurred while admitted to the Rehabilitation Centre will be covered under this benefit:

- occupational therapy fees
- special treatment room fees
- speech therapy fees

Rehabilitation centre services must be certified by a specialist as Medically Necessary. The factors to be considered in making such certification must include, but are not necessarily limited to:

- the type and severity of the Illness or Injury, and the Insured Person's overall state of health and prior treatment history;
- the amount of therapy expected to be performed every day;
- the risk of deterioration or non-recovery of function if therapy is not completed; and
- the extent to which the Insured Person will be able to perform activities of daily living during the rehabilitation period.

In all cases, We reserve the right to require re-authorisation of Rehabilitation Centre services at any time upon notice to the insured.

S. **SEXUALLY TRANSMITTED DISEASE:** Illness classified as an infection with a predominantly sexual mode of transmission in the International Classification of Diseases 10th Revision (2025 version).

S. **SLEEP APNOEA DIAGNOSTICS AND TREATMENT:** Refers to the assessment and management of Sleep Apnoea, including:

- Sleep Studies: Diagnostic procedures such as polysomnography, conducted overnight in a licensed Hospital or accredited sleep Clinic to confirm the presence and severity of Sleep Apnoea.
- CPAP Therapy: Use of a Continuous Positive Airway Pressure (CPAP) machine prescribed by a licensed medical practitioner to treat Sleep Apnoea. This includes the Initial purchase or rental of CPAP machine.
- Oral Appliances: Custom-fitted oral devices prescribed by a qualified Dentist or medical doctor to treat Sleep Apnoea, typically for mild to moderate cases or when CPAP is not tolerated.

The coverage applies only when services are deemed Medically Necessary and prescribed by a licensed medical practitioner. Expenses for Sleep Apnoea Diagnostics & Treatment may only be claimed under the Sleep Apnoea Diagnostics & Treatment section of the benefits schedule, and no other type of benefit under this policy provides coverage in connection with Sleep Apnoea Diagnostics & Treatment.

S. **SLEEP APNOEA SURGICAL TREATMENT:** This benefit includes surgical procedures aimed at alleviating OSA by modifying upper airway structures. If the OSA diagnosis is clinical only and the Physician confirm that this is linked to OSA, We will decline. Covered surgeries may include:

- Uvulopalatopharyngoplasty (UPPP)
- Tonsillectomy and/or adenoidectomy
- Maxillomandibular advancement (MMA)
- Hypoglossal nerve stimulation (e.g., Inspire therapy)
- Nasal surgeries (e.g., septoplasty, turbinate reduction)
- Tracheostomy (in severe cases)

The coverage is subject to the confirmation of OSA diagnosis via polysomnography, a documentation of failed or contraindicated non-surgical treatments (e.g., CPAP intolerance) and a Pre-authorization and approval by the insurer. Expenses for Sleep Apnoea Surgical Treatment may only be claimed under the Sleep Apnoea Surgical Treatment section of the benefits schedule, and no other type of benefit under this policy provides coverage in connection with Sleep Apnoea Surgical Treatment.

S. **STEM CELL TREATMENT:** Treatment for a Disability where an immediate advantage over other available treatment options can be identified and verified by us. Preventive treatment is not included. Cover is subject to medical necessity and our Pre-authorisation. Where applicable, only FDA-approved hematopoietic stem cell transplantation (HSCT) for specific indications will be considered.

S. **SUDDEN ILLNESS OR INJURY:** For the purpose of treatment received outside your Area of Cover, a sudden Illness or Injury means either:

- a Disability occurring wholly and exclusively during the first 30 Travel Days of any trip outside your area of cover; or
- a Disability existing prior to a trip outside your area of cover which had not required any advice (other than routine follow-up), treatment or any new/changed medication in the 30 days prior to the time You commenced your journey.

In the case of an Injury, the Accident must occur during the trip in which treatment is obtained. Sudden Illness or Injury does not include any Disability of which symptoms existed prior to the start of the trip and which would have caused a reasonable person to seek medical care, and it does not include pregnancy or Complications of Pregnancy.

S. **SURGERY:** Cutting or destruction of tissue performed by a Physician involving the use of surgical instruments, ultrasound, heat, cold, or radiation. It also includes reduction of broken bones or manipulation of a joint under anaesthesia, when performed by a Physician.

S. **SURGICAL IMPLANTS:** A device or devices which are surgically implanted to form a permanent or long-term part of the body but does not include External Prosthesis.

T. **TERMINAL CONDITION/ILLNESS:** An Illness that is approaching its final stages, for which treatment can no longer be expected to cure and will lead to death (life expectancy being a matter of months). In all circumstances, treatments for Terminal Illnesses must be pre-approved by us. We reserve the right to consider any treatment for a Terminal Illness as Palliative and to apply the corresponding limits of your Benefits Schedule.

T. **TERRORIST ACT:** An act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist act can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of a Terrorist Act can either be acting alone, or on behalf of, or in connection with any organisation(s) or government(s).

T. **THERAPEUTIC ABORTION / MEDICAL NECESSARY ABORTION:** The termination of a pregnancy that is deemed Medically Necessary due to an underlying or life-threatening condition that endangers the mother's physical health or in the event of a confirmed fetal abnormality.

T. **TRAVEL DAYS:** Successive 24-hour periods between the time You first arrive at an international border of a country outside your Country of Residence, and the time You next arrive at an international border of a country within your area of cover.

U. **UNITED STATES OF AMERICA (USA):** The United States of America (including its territories and possessions).

W. **WAITING PERIOD:** The period during which the related insurance benefits are not covered. This includes any Claims submitted after the Waiting Period if the medical Expenses or the consequences of medical treatment occurred during the Waiting Period.

W. **WAR:** War, whether declared or not, or any warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious, or other ends.

W. **WE, US, OUR:** Seib Insurance & Reinsurance Company LLC, a company Authorized by the Qatar Financial Center Regulatory Authority (QFCRA), Qatar Financial Centre (QFC) License number 00114 and having its offices at Airport Road Sheikh Jabor Bin Youssef Bin Jassem Al Thani Building, Ground Floor, P.O. Box 10973 Doha – Qatar.

Y. **YOU, YOUR:** The Policyholder and/or Insured Person and/or his or her Dependents named in the policy pack.

SECTION E: ADDITIONAL POLICY ADMINISTRATION AND GENERAL INSURANCE CONDITIONS

MyHEALTH Qatar – Terms and Conditions
This section forms an integral part of the MyHEALTH Qatar – Terms and Conditions, effective as of the same date, and shall prevail in the event of inconsistency, solely in respect of the matters addressed herein.

1. Basis of Policy and Validity
This Policy is issued based on the application form, medical quotation, underwriting information, and related correspondence submitted by the Policyholder, all of which form part of the contractual basis of cover.
This Policy shall not be valid unless confirmed by a policy schedule duly signed or issued by the Insurer. Any amendment, addition, or variation shall be valid only if expressly confirmed in writing by the Insurer.

2. Records and Verification
The Policyholder shall maintain accurate records relating to the Policy and the Insured Persons. The Insurer reserves the right, upon reasonable request, to inspect such records. Clerical errors shall not invalidate a valid Policy; however, the Insurer may apply an equitable premium adjustment where appropriate.

3. Eligibility and Age Limits
Eligibility for cover, dependent definitions, age limits, and any extensions beyond standard age thresholds shall apply in accordance with the Insurer's underwriting guidelines and confirmations. Any continuation of cover beyond age 65 shall be subject to underwriting approval and additional premium.

4. Commencement of Cover
Coverage shall commence only once the Policy has been issued or confirmed by the Insurer and the applicable premium has been paid in accordance with insurer requirements.

5. Premium Payment and Grace Period
Premiums shall be paid in accordance with the invoicing terms. A grace period may apply as confirmed by the Insurer. Failure to settle premiums may result in suspension or termination of cover and recovery of claims paid. All payments shall be made in the currency stated in the Policy Schedule.

6. Access Cards
Insurance access cards remain the property of the Insurer. The Policyholder shall be responsible for their proper use, timely return upon termination, and any losses resulting from misuse or failure to report loss or theft.

7. Automatic Termination
Coverage under this Policy shall terminate automatically upon occurrence of any event resulting in loss of eligibility, exhaustion of benefits, fraud, misuse, or attainment of the maximum permitted age, in accordance with Policy terms.

8. Cancellation and Financial Settlement
Cancellation and refund of premiums, where applicable, shall be determined based on the effective date of cancellation, claims history, and applicable insurer refund rules, including any short-period rate calculations.

9. Extension of Benefits
Where an Insured Person is totally disabled at the effective date of termination, benefits may be temporarily extended solely in respect of the disabling condition, subject to Insurer confirmation and applicable limits.

10. Reimbursement and Recovery
The Policyholder shall reimburse the Insurer for any amounts paid due to overpayment, misuse, ineligibility, or breach of Policy terms. The Insurer's right of recovery shall apply without prejudice to any other rights.

11. Notices
All notices to the Insurer shall be made in writing by recognised means and shall be deemed received upon actual receipt.

12. Governing Law
This Section shall be governed by and construed in accordance with the laws of the State of Qatar.

MH QT 2026/02

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