SECTION 1: Definitions
The following words, terms and expressions shall bear the meanings corresponding to them whenever they appear herein this document unless otherwise required by the context:

1. ACCESS CARD
A personalized card, also referred to as the Insurance ID Card, issued in the name of each Insured, facilitating his/her access to the healthcare services covered under this Policy. It is the property of the Insurance Company.

2. ACCIDENT
Any sudden or unforeseen event occurring during the policy period, resulting in bodily injury, the cause or one of the causes of which is external to the victim’s own body and occurs beyond the victim’s control.

3. ACTIVELY ENROLLED
On the date a group insurance contract becomes effective, student A is not enrolled at the university because of accident or sickness. Under an actively-at-university-provision, student A would not be eligible for coverage until he/she returns to full time study.

4. ADDENDUM
A document issued upon a request of policyholder by the Insurance Company on an official form dated and signed by an authorized student as a proof of accuracy of any amendments to the policy, provided that it does not affect the basic coverage.

5. ADMINISTRATOR
The appointed company or party or department of the Insurance Company that is always acting in the name and on behalf of the Insurance Company in administering this Policy in part, and in supporting and monitoring its proper implementation, through its offices and delegates (e.g. physicians and other delegates). Particularly, the Administrator continuously verifies the eligibility of the Insured to the healthcare services sought and takes the decision, in the name and on behalf of the Insurance Company, as to whether to grant or not the Approval of Coverage. To that effect, the Administrator follows up the Insured medical and accounting files and coordinates with the attending physicians when needed.

6. ADMINISTRATOR HEALTHCARE PROVIDERS
The Providers of specific Healthcare Services (e.g. hospitals, medical centers, integrated clinics, pharmacies, laboratories, physiotherapy centers, physicians), that spread throughout certain territories and that are adherent to the Administrator healthcare service providers Network, to provide part or whole of the available healthcare services. In addition, healthcare centers in other countries as per the policy schedule whenever such centers are contracted with the Administrator either directly or indirectly through another entity cooperating with the Administrator.

A list of Administrator’s Healthcare Providers is available upon request with the Insurance Company or the Administrator. These Healthcare Providers or parts of their services or sections may be modified during the Policy Period (added or reduced) without the need to the prior notification of the Policyholder or his approval.

7. ALLERGY
A bodily condition causing a person to be vulnerable when coming across some types of food, material, weather, pollens, animal, insects, plants, metals, elements or any other material causing person to suffer from physical responses resulting from direct or indirect contact with those material leading to asthma, maldigestion, itching, hay fever, eczema, or headache.

8. AMBULATORY/PRESCRIPTION MEDICINE TRANSACTION
A virtual electronic form; processed through the personalized Access Card of the Insured. It allows the Insured to benefit, when applicable, from the Ambulatory Healthcare Benefit Plan and/or the Prescription Medicine Benefit Plan; it must be used based on a duly completed signed and sealed medical report issued by the Insured’s attending physician. The medical report is valid for 15 days following completion by the attending physician, and should be duly written, dated, signed, and stamped by the attending physician.
The Ambulatory/Prescription Medicine Transaction and the proper implementation of the above conditions and procedures are a mandatory prerequisite to benefiting from the coverage of the Ambulatory and/or Prescription Medicine Benefit Plan coverage.

9. APPLICABLE PLAN
The set of healthcare benefits provided for in the Policy, along with their Limitations and Exclusions specifically identified as approved for coverage, for each Insured, in the Policy Schedule.

10. APPLICATION
It is the form that you complete for cover under this Policy.

11. BENEFICIARY (INSURED)
A person covered by Law included in the list of those insured declared by the Policyholder to the Insurance Company.

12. BENEFIT
The expenses of providing services included in the insurance coverage with the limitations shown in the policy schedule.

13. CHRONIC CONDITION
A chronic condition is a disease illness or injury which has at least one of the following characteristics: continues on indefinitely and has no known cure; permanent; needs long term monitoring, consultations, check-ups examinations or tests.

14. CLAIM
A demand made by the Insured for payment of the benefits as provided by the policy.

15. CLAIM SUPPORTING DOCUMENTS
All documents that support and confirm age, nationality and identity of the insured, validity of the insurance coverage, and details of the incident that were the basis for the claim. They also include other documents such as police reports, invoices, receipts, prescriptions, doctor’s report, recommendations and any other original documents that may be required by the Insurance Company.

16. CO-INSURANCE
The portion of costs for which the Insured is liable. The co-insurance will be applied as specified in the Table of Benefits.

17. COMMENCEMENT DATE also INCEPTION DATE
The date indicated on the policy schedule where the insurance coverage commences.

18. CONGENITAL DEFORMITY
A congenital functional, chemical or structural defect whether inherited or resulting later.

19. CORPSE/BODY REPATRIATION
The expense of preparation and air transportation of the mortal remains of the Insured from the place of death to the Home Country, or the preparation and local burial or cremation of the mortal remains of an Insured who dies outside his Home Country.

20. COVERAGE LIMITATIONS
The maximum limitation of the Insurance Company’s responsibility as defined by the policy schedule for any insured person before applying any deductions or encumbrances.

21. DEDUCTIBLE
The percentage or amount of the incurred expenses to be borne by the Policyholder and paid by the Insured.
22. STUDENT
Full-time students actively attending classes for at least the first 31 days after their enrollment date. Eligibility requirements are not met for students taking online courses or taking courses through home study or by correspondence. If the Company finds out that students do not meet the eligibility requirements, a cancellation will be effected in line with the agreed on cancellation method.

23. ENROLLMENT DATE
00:00 hours of the day, month and year appearing on the Policy Schedule, on which the Insured has been enrolled, under this Policy, for the first time with the Insurance Company.

24. EVENT
Any accidental or unexpected occurrence happening during validity of insurance coverage.

25. EXCLUSION
A risk that the policy does not cover.

26. FRAUD
Intentional circulation of misleading tips by person or body for exploitation of healthcare system or manipulation of data or purposed cheating resulting in managing benefits or provision of exceptional benefits or overriding permissible coverage limitations.

27. GROUP BUSINESS
A business that comprises of at least 10 full time students enrolled by the Policyholder that applied for this insurance and accepted by the Insurance Company and considered to be a Group for the purpose of this policy. Eligible students will be automatically enrolled under this Policy unless they present a valid proof of comparable insurance coverage.

28. HOSPITAL
A health facility approved by / acceptable to policyholder and the Insurance Company and licensed to operate in accordance with applicable regulations to offer treatment for which it may claim reimbursement in accordance with this policy. The word “hospital” as used in this policy does not include hotels, hostels, guest houses, rest houses, resorts, sanatoriums, old age homes, mentally retarded hospital, or any place used to accommodate drug or alcohol addicts.

29. HOSPITALIZATION
Admitting an insured person as a patient to be hospitalized until the next morning based on referral by a licensed doctor.

30. ILLNESS
An affection or disease attacking a person insured that requires a medical treatment through a licensed doctor during validity of insurance coverage.

31. INSURANCE
Proof of insurance coverage in accordance with this policy and its schedule, addenda or attachments.

32. INSURANCE COVERAGE
Basic health benefits made available to the beneficiary as specified in the insurance policy.

33. INSURANCE COMPANY
The Insurance Company duly registered and authorized to operate in Qatar, which guarantees the payment of the benefits provided under this Policy.

34. INSURANCE DURATION
The period indicated in the policy schedule during which the insurance remains valid.
35. **INSURED**
The Policyholder and/or any other natural person listed in the application or included thereafter, formally accepted by the Insurance Company and listed in the Policy Schedule.

36. **LICENSED DOCTOR**
A medical practitioner with relevant qualification and lawfully licensed to practice medicine, and approved by policyholder and the Insurance Company to provide treatment subject to cost reimbursement in accordance with this policy.

37. **MEDICAL DOCTOR PLAN TRANSACTION**
A transaction allowing the beneficiary to benefit, when applicable, from the MD Benefit Plan. Must be used based on a duly completed signed and sealed medical report issued by the Insured’s attending physician. The MD Transaction and the proper implementation of the above conditions and procedures are a mandatory prerequisite to benefiting from the MD Plan coverage.

38. **MEDICAL REPORT FOR ADMISSION (M.R.A.)**
A form available at request from the Administrator that must be completed by the attending physician of the Insured and submitted to the Medical Officer of the Administrator prior to hospitalization. It is a mandatory prerequisite to benefit from the In-Hospital coverage.

39. **MISUSE**
Unintentional practices by individuals or bodies to win privileges or benefits through illegal means but without the intention of cheating, lying or misinterpretation of facts in order to get privilege or interest.

40. **OUTPATIENT TREATMENT**
Visits made by an insured person to an out-patient clinic for diagnosis or treatment of a disease or injury.

41. **PERSONAL RISK**
Any practice performed by a person known to be of high risk in the form of affection, accident, or aggravation to a disease of previous latent symptoms.

42. **PHYSICIAN**
A doctor or surgeon who is a doctor of medicine or equivalent, legally licensed to practice medicine and qualified to render the treatment provided.

43. **POLICYHOLDER**
The entity for whom the policy was issued and that is entitled to request insurance coverage for its eligible students subject to the underwriting conditions of the Insurance Company.

44. **PREEXISTING CONDITION**
A Pre Existing condition is an illness, injury, condition or symptom that originated prior to the insured coverage date (policy enrollment date) whether known or un-known to the insured prior to the policy enrollment date; but considered as medically pre-existing (present in the body prior to the commencement of insurance).

45. **PREMIUM**
The amount paid by policyholder for the insurance coverage provided by the policy during the insurance validity.

46. **REHABILITATION (PHYSIOTHERAPY)**
Is an integral part of comprehensive healthcare service and its applications aimed to restore injured person to normal physical and social life.

47. **RENEWAL EFFECTIVE DATE**
00:00 hours of the day, month, and year appearing in the Policy Schedule, at which the Insurance Company is deemed to have formally accepted to renew this Policy having been in force and effect without interruption, following the due signature, by the Policyholder of the Policy documents and the payment of the due premium on time.
48. **REASONABLE AND CUSTOMARY MEDICAL EXPENSES**

- The medical expenses that coincide with the average charges collected by the majority of licensed doctors or hospitals within the applicable area of coverage stated in the Policy, for identical cases provided that such doctors or hospitals are equally qualified as those who offered the treatment.
- The medical treatment that does not vitally differ from those considered acceptable by the licensed doctor as being normal and natural for any disease or treatment for which the related medical expenses are claimed in accordance with this policy.

49. **SERVICE PROVIDER**

The person or health facility approved and licensed in accordance with applicable regulations to provide medical services in a territory that is covered by the policy. For example, hospital, diagnostic center, clinic, pharmacy, laboratory, physiotherapy or radiotherapy center.

The insurance company reserves the right to modify the list of medical providers at any time during policy duration and notify the policy holder accordingly.

50. **SURGERY OR ONE-DAY TREATMENT**

Surgery or treatment that requires pre-arrangement for admission to a hospital or treatment center for one day but does require hospitalization until the next day.

51. **VALIDITY DATE**

The date fixed by policyholder and approved by the Insurance Company for the commencement of the coverage in accordance with this policy.

52. **VALIDITY DURATION / GRACE PERIOD**

Number of days during which the policy remains valid in case of non-payment of all premiums indicated in the schedule.

**SECTION 2: Scope of Insurance Coverage and Exclusions**

The Insurance Company shall cover all reasonable, customary and usual expenses related to healthcare services, and incurred by the Insured under an applicable Healthcare Plan selected by the Policyholder under this Policy during the policy period and while this Policy is in force and subject to its Terms, Conditions, Limitations and Exclusions and in excess of any applicable deductible and other expenses that should be borne by the insured. Therefore, payable expenses shall include the following:

**2.1 In-Hospital healthcare Benefits**

The Insurance Company covers strictly the following as In-Hospital healthcare benefits:

a. The treatment (medical or surgical or endoscopic) of covered healthcare conditions, provided always that such treatment cannot be undergone on an **ambulatory** basis, as defined hereinafter, and requires an uninterrupted hospital confinement initiated during the Policy contractual period.

b. All diagnostic endoscopic procedures and all surgical procedures (conventional or endoscopic) and all treatments of covered healthcare conditions, that do not require an overnight stay at the hospital are covered in the “one day room unit” under the class agreed to with the hospital, irrespective of the class of hospitalization of the **Insured**, such as gastroscopy, chemotherapy, radiotherapy, excision of lymph node.

c. Emergency treatments defined as follows: the treatment (medical or surgical) which may not be delayed, delivered in a hospital emergency room, of all accidents or incidents of sudden sickness, providing a legitimate professional concern that there may be a significant medical problem, provided that its covered by this policy.

d. Physiotherapy treatment related to a covered hospitalization, whether delivered at the hospital or outside, during the contractual period of the Policy.

e. Any medical treatment requiring a hospitalization service or its equivalent that starts at a hospitalization center, and can be continued for a specific period of time at the **Insured**'s home provided that this does not include rest cures, by an entity specialized in giving the hospitalization treatments and that is according to the decision and approval of the physician, and the prior authorization of the **Administrator**, without putting the **Insured**'s health at any risk.
f. The prosthesis related to a surgery as a result of a severe accident during the period of the policy or its successive renewals (excluding orthosis), provided that the prosthesis are covered either promptly after the accident or during a period of 6 months that proceeds the date of accident, provided that the coverage of the insured within the scope of the Policy is continuous without interruption ever since the accident date.

2.1.1 In-hospital Healthcare Benefits Limitations

The **Insured** will be covered:

a. In the covered territory under the hospitalization class identified in the Policy Schedule with the exception of the hospitalization processes that do not require an In-Hospital stay which are listed in Section 2.1 in the scope of In-Hospital healthcare benefits above.

b. When maternity is covered under this Policy, the **Insurance Company** will bear the boarding costs of a nursery and/or the use of an incubator for the newborn baby, as of birth for as long as the required period of treatment is, and irrespective of the period of stay of the mother, in addition to the fees of not more than two consultations of the attending pediatrician. The above will apply for a covered hospital confinement under both normal deliveries and cesarean sections.

c. Coverage of all congenital deformities that are considered life threatening. In addition to congenital cases that were neither diagnosed nor treated previously, and the complications that occur there from, which arise during the effective period of the policy.

d. Appendectomy will be covered; however the coverage of the use of Laparoscopic materials will be subject to the prior approval of the Administrator.

2.1.2 In-Hospital Healthcare Benefits Exclusions

Unless otherwise specifically referred to in the Schedule of Benefits, the Insurance Company does not cover the following conditions, the complications and the consequences arising there from whether directly or indirectly:

a. All the cases that have exceeded the limitations per Insured provided for in the Policy schedule or the amendments that may not appear here below.

b. All Ambulatory healthcare services (e.g. diagnostic tests, check-up tests, treatments, vaccination, the services delivered by the physician at his clinic, medical center or out-patient hospital facility) that may be medically justified but do not mandate hospital confinement.

c. Any hospitalization not medically mandatory for the Insured’s health (e.g. sight correction tests and procedures)

d. Congenital conditions which are not life threatening.

e. Any treatment or procedure, which is still experimental, and all kinds of genetic tests and procedures (whether medical or surgical) including genetic engineering and cloning.

f. Claims relating to preexisting conditions. Unless as specifically referred to in the schedule of benefits.

Any waiver of pre-existing conditions does not have any effect on the other exclusions listed in the Policy, that remain in full force and effect.

In all instances, the Policyholder and the Insured remain subject to the duty of full disclosure and full declaration of their health condition as well as any fact relating thereto. Thus, any false declaration or non-disclosure made by the Policyholder and/or by the Insured, discovered at any time, will render this Policy null and void from validity date without the need for a written notice, pursuant to Article 3.12 of the Policy, even if the Insured has benefited from the waiver of the pre-existing condition exclusion.

g. Sleep disorder cases, tests, procedures and surgeries related thereto including polysomnography **unless** specifically referred to under the schedule of benefits.

h. Mental or psychiatric disorders, nervous breakdowns, and psychological tests or evaluation or therapy, occupational therapy and any kind of dementia including Alzheimer’s disease, unless specifically referred to under the schedule of benefits.

i. Rest cures, sanatorium, custodial care and periods of quarantine, special diets and weight control procedures and surgeries, costs related to convalescence even when initial hospitalization was covered under the Policy.

j. Any claim relating to suicide, self-inflicted injury or any such attempt whether the Insured is sane or insane, or resulting from the impairment of an Insured’s intellectual faculties by abuse of stimulants or depressants or by the illegal use of any solid, liquid or gaseous substance.

k. Any claim relating to Alcoholism, drugs and like substances; addiction to and abuse of medicines under no medical supervision, and all consequences arising there from, unless specifically referred to under the schedule of benefits.

l. Claims arising from the Insured taking active participation or involvement in any of the following events: war, acts of terror, warlike activities, civil strife and commotion, crimes and misdemeanors; any claim arising from an illegal act of the Insured during his stay in prison.
m. Treatment of injuries and sickness consequent to the participation of the Insured, either as an amateur or professional, in the following hazardous sports (motor or motorcycle racing, deep sea diving, scuba-diving, snorkeling, parachuting, hang gliding, delta-plane, rock climbing or mountaineering, hunting on camel or horseback, jet skiing).

n. Claims arising from Radioactive contamination, ionizing radiation, radioactive, toxic, explosive or other hazardous properties of nuclear material thereof, and/or polluting hazardous or poisoning chemicals.

o. All cosmetic and/or plastic surgeries unless necessitated by an accident. All procedures relating to the treatment (medical or surgical) of the falling of hair and treatment of hirsutism and all consequences related thereto unless it is related to a covered medical condition.

p. The surgery and cost of all kinds of organ transplantation, other than heart liver and kidney and the cost of acquisition of such organs and all expenses incurred by donor are excluded hereon.

q. The cost of all kinds of prosthesis and orthosis replacing an organ, limb, tissue, cell or any function of the human body (e.g.: all types of pacemakers) including resorbable prosthesis, limbs or tissues; as an exception to this exclusion, the prosthesis, covered in the scope of In-Hospital coverage, are covered as indicated in this policy herein above.

r. Maternity related expenses, the delivery process and the Epidural, Dental, Optical Benefits unless listed in the Policy schedule.

s. Amniocentesis and Abortion that is not medically mandated to the same matter are permanently excluded from coverage and cannot benefit from the above waiver.

t. Tubal ligation, as well as all birth control procedures and their consequences, treatment of impotence, Infertility, sterility, and all screening tests, medication and treatments related thereto and their consequences, including colonoscopy and hysteroscopy, In-vitro and Ex-vitro or any other artificial insemination procedures. All procedures related to the change of sex. All sexual fortifying products medicines (e.g. Viagra) and procedures, and the treatment of all consequences related thereto, contraceptive medicine and methods.

u. Human Immune Deficiency Virus (H.I.V.), AIDS and all screening tests, medications and treatments related thereto.

v. Expenses incurred for treatment or care at long term care facilities, old age home, healthcare and diet resorts, and institutions for mentally disabled, lunatic asylums.

w. All expenses not directly related to the treatment of a medical condition such as: Air ambulance expenses, car hire expenses, Hearing aids, spectacles and contact lenses, wheelchair, orthopedic equipment and over the counter products related to diet regimen or reduction of weight.

x. All treatments related to speech therapy, alternative medicine treatment, acupuncture, homeopathic.

y. Diseases acknowledged by the WHO as epidemic or pandemic.

z. Any treatment by a close relative or family member even if a licensed practitioner.

aa. Work related accidents and/or injuries.

ab. Developmental Disorders.

ac. Road Traffic Accidents unless specifically referred to under the schedule of benefits.

ad. Rehabilitation unless specifically referred to under the schedule of benefits.

2.2 Ambulatory Healthcare Benefits

The Insurance Company covers as Ambulatory healthcare benefits, the diagnostic tests and treatments strictly listed hereunder, which do not require In-Hospital confinement.

a. Diagnostic Tests:

b. Treatment:
Laser therapy, Physiotherapy, and Kinesitherapy.

c. Physicians’ fees relating to the necessary interpretation of technically specialized tests are covered, provided they are conducted at the same facilities where tests were performed.

2.2.1 Ambulatory Healthcare Benefits – Limitations

All Ambulatory Healthcare Benefits are limited to the healthcare services delivered through a Provider approved by the Insurance Company in the covered territory, as per the following procedures:

a. The Insurance Company covers the Ambulatory healthcare expenses, as per the policy schedule

b. Prior approval of the Administrator required for the use of MRI Osteodensitometry, or other benefits referred to in the schedule of benefits.

2.2.2 Ambulatory Healthcare Benefits - Exclusions

Unless otherwise specifically referred to in the Schedule of Benefits, all exclusions applicable to the In-Hospital plan are applicable
to the Ambulatory Plan, in addition to the following cases:

1. Expenses related to medical Checkups
2. Expenses related to Physicians’ fees.
3. All tests related to infertility (e.g. spermogram, hysterosalpingography, spermoculture, testicular pelvic echo doppler).
4. Human Immune Deficiency Virus (H.I.V.), AIDS and all screening tests, medications and treatments related thereto.
5. All tests related to congenital cases, unless the congenital condition is life threatening to the insured.

2.3 Prescription Medicines
a. The Insurance Company covers under the Prescription Medicine Benefit Plan the medicines duly registered and approved by the Ministry of Health, and as per the tariffs set by the latter, prescribed by the Insured’s attending physician, but excluding the physician fees.
b. The quantity of covered prescribed medicines per transaction is limited to the normal, usual and customary need for a maximum of one month of treatment per transaction.

2.3.1 Prescription Medicines – Limitations
a. All the benefits of the Prescription Medicine Benefit Plan are limited to products prescribed by the treating physician and dispensed through a provider approved by the Insurance Company in the covered territory.
b. An Insured over 6 (six) years of age does not benefit from the vaccination cover.

2.3.2 Prescription Medicines – Exclusions
Unless otherwise specifically referred to in the Schedule of Benefits, this plan excludes:
a. All over-the-counter products that can be dispensed with or without a medical prescription (e.g. beauty and cosmetic items, vitamins and mineral products, personal, baby food and household hygiene products, antiseptic products and products related to diet regimen). All homeopathy and phototherapy products.
b. All hair treatment products.
c. All products for dental care or for the gum (e.g. hygienic or treatment products).
d. All sexual fortifying products. All products and medicines for contraception and for the treatment of sterility, impotence and infertility.
e. All products related to the treatment of mental disorders, (such as psychosis, anxiety, depression, mania, etc.). In addition to amphetaminic, hypnotic and sedative products.
f. Dietetic products for all ages (e.g. milk, nutritional and diet products).
g. Dermatological products except those used for the treatment of allergic reactions, infectious diseases (e.g. chicken pox), or consequences of accidents (e.g. burns).
h. All medicines used for the treatment of a pre-existing medical condition, unless specifically referred to under the schedule of benefits.
i. All hearing and optical apparatuses (e.g. lenses, glasses) and the products used for their cleaning and upkeep.
j. All medications related to Human Immune Deficiency Virus (H.I.V.), AIDS.
k. All drugs not prescribed by a doctor.
l. Vaccination except for children that are below 6 years of age.
m. All exclusions applicable to the In-Hospital plan are applicable to the Prescription Medicines plan.

2.4 Medical Doctor (M.D.) HealthCare Benefits
The Insurance Company covers exclusively the following as M.D. Healthcare Benefits.
The full fees and expenses related to the medical services and procedures listed hereunder, rendered by a physician approved by the Insurance Company:
a. The normal, usual and customary consultation.
b. The following diagnostic services: Cardiac Echo Doppler, Arterial Echo Doppler, Electrocardiogram, Cardiac Stress Test, Pulmonary Function Tests (e.g. Spirometry), Ultrasonography, Electroencephalogram, Electromyogram, Audiogram.
c. Minor surgery and endoscopic procedures not requiring an operating room or emergency room or hospital services.

2.4.1 M.D. Healthcare Benefits - Limitations
The Insurance Company shall reimburse the necessary reasonable and customary medical expenses incurred by an Insured for All M.D. Benefits for healthcare services delivered through a licensed physician at the latter’s clinic, or at licensed polyclinics and hospitals, in excess of the applicable deductible as per the policy schedule and during the period of the policy and as long as the policy remains in force.
2.4.2 M.D. Healthcare Benefits – Exclusions

Unless otherwise specifically referred to in the Schedule of Benefits, all exclusions applicable to the In Hospital plan are applicable to M.D. Plan

2.5 Procedure for claim reimbursement

2.5.1 When the reimbursement procedure is applicable, payment is effected on the condition that the Insured completes and submits a duly written request for reimbursement, together with the following documents:

a. A detailed report from the attending physician identifying the nature and reason of the services rendered.

b. A photocopy/scanned copy of the Access Card.

c. The original receipts and bills issued by the attending physicians having performed the services.

d. A photocopy/scanned copy of the results and diagnostic related to the services rendered, when applicable.

2.5.2 Reimbursement will be only effected provided that the documents mentioned above are filed with the Insurance Company within 31 days from the date of the services rendered but extended to 90 days for claims arising from outside the country where the policy was issued.

2.6 War Exclusion

Notwithstanding any provision to the contrary within this Policy, or any endorsement thereto, it is agreed that this Policy excludes any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense:

(1) War, hostilities or warlike operations (whether war be declared or not), invasion, act of an enemy foreign to the country which is the underlying territory of the Insurance Company or the principal residence of each insured person affected,

(2) Civil war, riot, rebellion, insurrection, revolution, mutiny

(3) Overthrow of the legally constituted government,

(4) Civil commotion assuming the proportions of, or amounting to, an uprising,

(5) Military take over of power or usurped power, military uprising, martial law or state of siege

Also excluded hereon is any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to any, or all, of (1) to (5) above.

If the Insurance Company alleges that by reason of this exclusion, any claim is not covered by this policy, the burden of proving the contrary shall be upon the Policyholder.

In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

2.7. Terrorism Exclusion

Notwithstanding any provision to the contrary within this Policy, or any endorsement thereto, it is agreed that this Policy excludes any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any act of terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense.

For the purpose of this exclusion:

Any act of terrorism means an act of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear. An act of terrorism can include, but shall not be limited to, the actual use of force, violence, disruption or subversion of communication and information system infrastructures and/or the contents thereof, sabotage or any other means to cause or intended to cause harm of whatever nature and/or the threat of such use. Furthermore, the perpetrators of an act of terrorism can either be acting alone, or on behalf of, or in connection with any organization(s) or government(s).

Also excluded hereon is any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above.

If the Insurance Company alleges that by reason of this exclusion, any claim is not covered by this Policy, the burden of proving the contrary shall be upon the Policyholder.

In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and
2.8 Prior Approval and / Second Medical Opinion Process

The Insurance Company shall apply a prior approval or obtain second medical opinion to certain proposed medical treatment, whereby a designated officer of the Insurance Company or of a designated Administrator reviews proposed inpatient hospital confinement, outpatient surgeries, physiotherapy, or other treatment that the Insurance Company finds necessary to include under this Process. Prior Approval is applied by the insured person, his attending physician, medical facility, and any other healthcare provider to assure that the insured’s specific medical needs are met in the most cost-effective setting suitable for treatment of the injury or sickness.

The Prior Approval intends to apply an evaluation of the medical necessity of the proposed treatment. Such medical evaluation may include an examination and diagnostic tests, but may not include treatment of the condition.

Alternative providers and courses of treatment or tests suggested by the Insurance Company are optional. The final decision as to the provider and course of treatment or tests for any medical condition rests with the insured person. However, if the insured person and his medical provider(s) agree to a more expensive method of medical treatment than that agreed to by the Insurance Company, the excess medical charges will not be covered under this Policy. If the Insured chooses not to use Prior Approval, the Insurance Company may reimburse the necessary reasonable and customary medical charges upon its own discretion.

Should the expense not be covered for any other reason set forth in this Policy, then such an expense may not be reimbursed by the Insurance Company even if Prior Approval was obtained.

SECTION 3 - General Conditions

3.1 Sanction Limitation and Exclusion

Notwithstanding anything agreed to the contrary expressly or implicitly under the terms of this Insurance Contract, no Insurer shall be deemed to provide cover and no Insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that Insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

3.2 Change In Law

In the event of any change in the law, whether arising from legislation, decisions of the courts or otherwise, at any time after the Insurer entered into this Agreement by which the Insurer’s liability hereunder is materially increased or extended the parties hereto agree to take up for immediate discussion at the request of either party a suitable revision in the terms of the Agreement. Failing agreement on such revision within thirty days after such a request it is agreed that the Insurer’s liability hereunder whensoever arising shall be determined as if the said change in law had not taken place.

3.3 Substantiating Validity

This policy represents the basic limit of the insurance coverage provided to the insured. It shall not be valid unless it is confirmed by a schedule signed by an authorized student of the Insurance Company. Likewise, the duration of any addition to this policy shall not be valid unless it is confirmed by an addendum signed by an authorized employee of the Insurance Company.

3.4 Records and Reports

The policyholder must maintain a record of written communication related to the policy including a copy of the application, the proposal, or the future requests made to the Insurance Company. The Policy is bound on the basis of information provided by the policyholder and the insured to the Insurance Company. Such records of the policyholder and the insured have a bearing on the insurance, accordingly the Insurance Company shall be allowed, when it desires, to inspect such records and ensure accuracy of the information provided by the policyholder. The Insurance Company, when required, shall provide policyholder with any data the policyholder desires to see concerning the insured person.

Clerical error in keeping the records shall not invalidate the policy that is otherwise validly in force nor continue insurance otherwise validly terminated, but upon discovery of such error an equitable adjustment of premium shall be made.

3.5 Eligibility for Insurance

3.5.1 Group Eligibility: A Group that has satisfied the Insurance Company underwriters and consists of not less than 10 members.

3.5.2 Student Eligibility: Full-time students actively attending classes for at least the first 31 days after their enrollment date. Eligibility requirements are not met for students taking online courses or taking courses through home study or by correspondence.
Residency should be within the policyholder area of coverage as approved by the Insurance Company.

If the Company finds out that students do not meet the eligibility requirements, a cancellation will be effected in line with the agreed on cancellation method.

### 3.6 Payment of the Premium

3.6.1 The policyholder undertakes to pay the insurance premium to the Insurance Company for the insured person at the beginning of the insurance coverage or as agreed upon mutually with the Insurance Company. The interval of payment may be changed, with appropriate adjustment, in line with the Insurance Company guidelines as confirmed and agreed in writing by the Insurance Company.

3.6.2 An interest free grace period of thirty-one days, will be granted for the payment of the premium due under the Policy on any due date, this grace period however, does not apply for the first premium payment at policy commencement or policy renewal date.

3.6.3 In case of non-payment of any part of the premium, on or after the expiration of the grace period, the policy shall not remain in effect for a period longer than that covered by the paid part of the premium, and the Insurance Company may report the nonpayment to the applicable legal authorities.

3.6.4 Should the Policy terminate during or at the end of the grace period, the Policyholder shall be liable to the Insurance Company for the payment of a pro rata premium for the time the Policy was in force during such grace period in addition to the any administration or policy fees, before the date of policy termination but after giving consideration to the clause 3.6.1 and clause 3.6.2.

3.6.5 Payment shall be made by methods of payments acceptable to the Insurance Company, at the Insurance Company offices, Insurance Company assigned collectors or collection offices; the Insurance Company may accept in writing to designate alternative offices or methods for the premium payment.

### 3.7 Currency

All payments by the Insurance Company under this Policy shall be made in the same currency as that in which premiums were received by the Insurance Company, unless otherwise arranged by mutual agreement between the policyholder and the Insurance Company.

### 3.8 Changes of Insurance coverage

Changes to the Insured Member Classification (promotion, upgrade, downgrade, etc...) can be done only on the next policy renewal date. In all cases, no change can be done to the insurance plan/class/category during the policy period.

### 3.9 Age Correction

If the age of an insured under this policy is misstated, there shall be an equitable adjustment of premiums under the policy, if the change in age affects the insured's insurance coverage, then such coverage shall be corrected accordingly and the premium adjustment shall take such correction into account.

### 3.10 Loss of Insurance Access Card/ Insurance ID Card

In case of loss of Access Card, the Insured must immediately notify the Insurance Company in writing, failing which any expenses incurred based on the usage of the non-reported lost Access Card shall be borne by the Policyholder.

### 3.11 Dates of the Coverage Validity

The insurance coverage for the student shall start as on the date of commencement of the policy and thus notified to the Insurance Company within 31 days of such commencement and accepted by the insurance company in writing of such enrollment.

### 3.12 Automatic Termination of insured Insurance Coverage

Students and dependents coverage under this policy terminates automatically and without notice in any of the following cases:

3.12.1 If the policy terminates.

3.12.2 Upon exhaustion or expenditure of the maximum benefits provided for in the policy.

3.12.3 Upon attainment of the maximum age allowed for under this policy.

3.12.4 In case of fraud or misuse of the insured Access Card by the insured or in the case of violation of the law in relation to this policy.

3.12.5 If the insured ceases to become full time student at university.

3.12.6 If the eligibility requirements upon which the insured coverage under this policy has been accepted became not valid, or non-existent, or can no longer be evidenced.

### 3.13 Termination / Cancellation of the Insurance Coverage:

3.13.1 The policyholder may cancel the policy by writing to the Insurance Company, by quoting the policy number,

1. without penalty during the initial 14 days of coverage, subject to
   a. no claims during this period and to
   b. all the original policy documents being returned to the Insurance Company.
c. no Access Cards have been issued by the Insurance Company or the Administrator, otherwise if issued, then a charge of QAR 7.00 per Access Card shall apply and paid to the Insurance Company.

d. Payment of all policy issuing and plan administrations fee.

2. If cancellation occurs after the above period; the Insurance Company will work out the premium for the period on pro-rata basis and as described in 3.14 hereinafter.

3.13.2 Without prejudice to section 3.13 above, the Insurance Company has the right to cancel the policy by sending the policyholder 31 days’ notice by registered letter to the policyholder declared address. As long as the policyholder returns the Access Cards to the Insurance Company, the Insurance Company will return the premium for the period of insurance still left to run without prejudice to other sections and clauses of this policy.

3.13.3 In case of termination of this policy for any reason, the policyholder must immediately return to the Insurance Company all Access Cards and by settling all amounts due to the Insurance Company, whether premiums, fees, claims or other expenses that the Insurance Company has paid or made a promise to pay on behalf of the Policyholder, and the same applies to the insured person whose insurance coverage comes to its end. The policyholder shall be responsible to compensate the Insurance Company for all medical costs and expenses resulting from its failure to comply.

3.14 Premium calculation in the case of Termination and Cancellation of the Policy Prior to the Renewal Date
Should the policy terminate, then all premiums due to the Insurance Company shall be paid to the latter calculated on pro-rata basis for the period the policy was in force after deducting all applicable administration fees, policy fees and charges. Any premiums paid by the policy holder to the insurance company for a period that falls after the policy termination date shall be refunded to the policyholder; however, under all circumstances, should termination occur prior to the policy renewal date, then refunded premium shall not exceed the total claims paid by the Insurance Company and pending under the policy and membership and plan administration fees; by deducting the total premium to be refunded to the policyholder from all (claims paid plus claims outstanding plus claims incurred but not reported plus administration fees).

3.15 Premium Calculation in the case of Termination of a Student
Should the coverage of an insured terminates, then all premiums due to the Insurance Company in relation to the terminated insured shall be paid to the latter calculated on pro-rata basis for the period the coverage was in force after deducting the membership administration fees and subject to no claims and return of insurance cards.

3.16 Fees and Expenses
This Policy in its provisions and conditions, schedule and endorsements including the annexes, supplementary contracts and other attachments thereto shall represent the entire rights and obligations of both parties to the contract (the Insurance Company and the Policyholder) and it shall not be admissible for either party to claim from the other party any right or obligation other than under the said attachments, otherwise the claiming party bears in full the expenses and fees incurred in respect of the said claim.

All levies, taxes, stamp duties and membership plan administration fees shall be borne by the policyholder in addition to the premiums stated in the policy schedule.

3.17 Extension of Benefits
If the Policy terminates for any reason, all benefits shall immediately cease, except as provided herein:
In the event that the Covered Individual is totally disabled, as defined in this section, at the time of such termination, coverage for such Covered Individual pertaining solely to the Disability which caused the total disability, shall be extended during the continuance of the total disability. In no event, however, will such benefits be payable for expenses incurred beyond the end of the month, following the month termination of individual insurance would normally occur.

3.18 Subrogation
The Insurance Company will subrogate the Insured in all his rights claims and lawsuits, which he/she may have against any third party liable for any obligation or expenses incurred based on whatsoever count or cause. In that case, both the Policyholder and the Insured undertake not to sign any release or discharge without the prior written approval of the Insurance Company and to provide the Insurance Company with all customary assistance and diligence, as if they were themselves claimants; should they breach this undertaking, they shall be liable to reimburse the Insurance Company with all amounts that could have been recovered from third parties.

3.19 Reimbursement Obligation of the Policyholder
The Policyholder shall be liable to reimburse the Insurance Company all claim amounts paid by the latter in the following cases:
a. Upon the settlement of any undue payment (e.g. Deductible).
b. If the Insurance Company pays in excess of the limits of benefits provided in the Policy, and or for benefits not covered by the policy.
c. Abuse or misuse of the benefits provided for under the Policy.
d. Abuse or misuse of the Access Card(s), or any other document delivered with the Policy document.

3.20 Deduction and Abatement
Notwithstanding the facilities granted under direct billing on the Insurance Company’s account, it is compulsory that the insured person pay his share of the claim, such as but not limited to the deductible at the service center. Any attempt by the insured to abstain from such payment shall be considered as a breach of the provisions and terms of the policy and shall render the policy invalid for this insured until payment of the claim amount has been made.

3.21 Treatment By Service Provider Not Approved by the Insurance Company
In emergency cases, an insured person may obtain medical treatment outside of the centers and hospitals approved by the Insurance Company on the basis of the compensation for alternative treatment. In such a case the Insurance Company, in accordance with the provision, terms limitations and exceptions of the policy, shall compensate the policyholder for the refundable expenses and cost provided that it provides the Insurance Company with the supporting documents within 60 days of incurring such expenses if the treatment took place in the state of Qatar; this period shall be extended to 90 days should the covered claim occurred outside Qatar.

3.22 Assignment
An Insured’s insurance shall not in this Policy be assigned to any person or entity.

3.23 Notices
Any notice or communication with the Insurance Company required per this policy shall be made only in writing.

3.24 Legal Recourse
This policy shall be governed by the laws of the State of Qatar and subject to jurisdiction of its courts.

SECTION 4 – Claims

Notice of Claim
Written notice of an occurrence upon which a claim under this Policy must be given to the Insurance Company within thirty (30) days of the date of such occurrence. Notice given by or on behalf of the insured student to the Insurance Company with particulars sufficient to identify the insured member, shall be deemed to be notice to the Insurance Company.

SECTION 5 – Signatures
The policyholder has read this policy and agreed upon it as well as the schedule and any annexes attached thereto. This policy has been executed in (2) two copies where every party received one copy to act upon it.

Date: 02/08/2022

Signature, Policyholder

Name: Nadia Basbous
Title: Chief Underwriting Officer-Life & Medical