GROUP HOSPITALISATION INSURANCE POLICY

In consideration of the payment of the required Premium, and the acceptance of a completed application (as required by the Company), the Company agrees to indemnify or compensate the Insured Members in the manner and to the extent provided in this Policy for medical or other covered expenses incurred during the period of insurance stated on the Benefit Table, or any subsequent period for which the Employer shall pay and the Company shall accept the required premium.

The Company has caused this Policy to be executed in Karachi, Pakistan, provided that this Policy shall not be binding upon the Company unless and until signed by a duly authorized representative of the Company. Furthermore, the Employer hereby agrees to indemnify the Company from and against any and all costs, losses and expenses incurred by the Company as a consequence of any failure by the Employer to discharge its responsibilities under this Policy.

1. PURPOSE

The purpose of this Policy is to set forth the terms upon which IGI Insurance Limited - Health Insurance Department (hereinafter called the "Company") will provide medical insurance (hereinafter called the "Cover") for the benefit of those employees of The Company mentioned as Insured (hereinafter called the "Employer"), as specified (hereinafter called the "Employees") and, subject to inclusion, their Dependents.

2. SCHEDULES

The Schedules and any subsequent Endorsements thereof form part of this Policy.

3. DEFINITIONS

Capitalized words and phrases used in this Policy, unless otherwise defined in this Policy, have the meanings set out in conditions, which are attached.

4. BENEFITS

Benefits are payable subject to the terms and conditions of this Policy for the period from 01 July, 2025 to 30 June, 2026.

BENEFITS	COVERAGE
1. SCOPE	PER PERSON PER ANNUM
2. TERRITORIAL COVERAGE	PAKISTAN ONLY
3. PRE-AUTHORIZATION	REQUIRED MANDAOTY FOR NON PANEL HOSPITAL TREATMENT
4. ACCIDENTAL EMERGENCIES	COVERED + 100% ENHANCEMENT IN IMC LIMIT IN CASE OF RTA INJURIES
5. PRE-HOSPITALIZATION	DIAGNOSIS, CONSULTATION & MEDICINE BOFORE AND AFTER 30 DAYS OF ADDMITION
6. DAYCARE PROCEDURES	COVERED AS PER POLICY
7. ICU CONFINEMENT	COVERED AS PER POLICY
8. SPECIALIZED INVESTIGATIONS	COVERED e.g., CT Scan, MRI, ECHO etc.
9. DENTAL TREATMENT	WHEN REQD. DUE TO ACCIDENT FOR PAIN RELIEF ONLY
10. LOCAL AMBULANCE	COVERED - TO AND BETWEEN HOSPITALS
11. CATARACT SURGERY	COVERED - WITH STANDARD FOLDABLE LENS ONLY
MATERNITY	
12. PRE & POST NATAL EXPENSES	COVERED UP TO 10,000/- SUBJECT TO AVAILABLE MATERNITY LIMIT
13. CIRCUMCISION BENEFIT	COVERED UP TO RS. 7,000/- SUBJECT TO AVAILABLE MATERNITY LIMIT
14. VACCINATIONS	1ST DOSE COVERED AT BIRTH FOR NEWBORN ONLY
15. FERTILITY, INFERTILITY AND CONTRACEPTION	NOT COVERED
SPECIAL BENEFITS	
16. PRE-EXISTING MEDICAL CONDITIONS	COVERED
17. PRE-EXISTING PREGNANCIES	COVERED
18. HEPATITIS B & C	COVERED
19. CONGENITAL CONDITIONS	COVERED
20. CLAIMS PROCESSING TAT	(15) WORKING DAYS, SUBJECT TO PROVISION OF ALL REQ. DOC.
21. VISITING CONSULTANT CHARGES	COVERED ON REIMBURSEMENT BASIS FOR HOSPITALIZATION ONLY.
22. DONOR'S TREATMENT	NOT COVERED
23. DEDUCTIBLE	REASONABLE & CUSTOMARY CHARGES WILL BE PAYABLE FOR TREATMENT AT NON PANEL HOSPITAL
24. MEDICAL EMERGENCIES	COVERED AT NMC LAHORE, FOR NON-PANEL EMERGENCIES IT WILL BE COVERED ON REIMBURSEMENT BASIS
26. HOSPITAL NETWORK	325+ FACILITIES NATIONWIDE (ATTACHED SEPARATELY)
27. EMERGENCY HOTLINE NOS.	ROUND THE CLOCK

NOTE:	
A. PERIOD OF INSURANCE COVER	12 MONTHS FROM A DATE TO BE AGREED
B. MAXIMUM AGE LIMIT FOR INPATIENT MEDICAL COVER	UP TO 75 YEARS FOR SELF & SPOUSE UP TO 25 YEARS FOR SON TILL MARRIAGE FOR DAUGHTERS
C. MAXIMUM AGE LIMIT FOR MATERNITY COVER	UP TO 44 YEARS
D. PREMIUM PAYMENT MODE	POLICY PREMIUM ON UP-FRONT BASIS & ENDORSEMENT ON QUARTERLY BASIS
E. HEALTH DECLARATION (Questionnaire Form)	WAIVED
F. VALIDITY OF THIS PROPOSAL	ONE MONTH FROM THE DATE OF ISSUE

5. ELIGIBILITY TERMS

5.1. The Employer hereby warrants that all of the Employees who meet the Company's underwriting criteria for inclusion, as of the Effective Date, will be included and that other employees who become eligible for inclusion subsequently will be included from the first day on which they become eligible.

5.2 Unless otherwise specifically agreed in writing.

5.2.1 Any Dependents who are eligible for inclusion will be included from the same date as the relevant Employee or from the date on which the person concerned first satisfied the definition of Dependent as contained in the terms and conditions of this Policy. If any Dependent is not included within thirty (30) days of the first date of becoming eligible, the Dependent may instead be included with effect from the beginning of the next Policy-Year. All eligible Dependents must be covered under the same plan as the Employee on whom they are dependent.

5.2.2 The Employer shall apply to the Company to add any new Employees that become eligible to join this Policy, by giving written notice to the Company and by submitting all documents that the Company may require in order to process the Application. The Company reserves the right to accept or decline any Application being made for an Employee to join this Policy and to charge the appropriate Premium.

5.2.3 The Employer shall, by giving written notice to the Company, withdraw any Employees who, for whatever reason, cease to be Employees. They will be withdrawn either:

a) from the date on which the Company receives written notice of their withdrawal; or
b) if later, from the date on which they leave the Employer's employment.

5.2.4 The Employer shall immediately advise both the Company and the Employee in writing when any Employee is no longer to be included and recover from the Employee, and any of his Dependents, any document which confirms the Employee's (and/or Dependent's) membership in this Policy. If the Employer fails to advise the Company or recover the appropriate documents for any reason, the Employer will remain responsible for the payment of the Premium until the date on which such notice is given, or to pay for any liabilities that may arise from the Employee's and/or his Dependent's continued use of this Policy.

5.2.5 Any Dependents shall cease to be included on the same date as the Employee ceases his participation in this Policy. However, when an Employee continues in employment with the Employer but the Company declines to cover the Employee under this Policy due to his existing health condition or due to his age, this condition shall not apply.

6. PREMIUM

6.1 The Employer shall be responsible for the payment of the Premium of all of its Employees and their respective Dependents that are included under this Policy.

6.2 At or prior to the commencement of each Policy-Year, the Company shall notify the Employer in writing of the Premium payable.

6.3 At each renewal, or monthly or quarterly if more appropriate, or following the termination of this Policy, the Company shall notify the Employer in terms of any additional Premium required or of any refund of Premium due following any adjustments.

6.4 All Premiums are immediately due and payable on written notification from the Company to the Employer. Premiums are payable in advance.

The Company reserves the right to charge a mark-up / profit at the rate of 1.5% per month, in the event that the Company receives the Premium more than fifteen (15) days after it was due and payable. Such interest shall be charged from the due date until the date of receipt of the payment of the Premium by the Company, both days inclusive.

6.5 Premiums paid by the Employer to any person other than an authorized agent or broker of the Company shall be received and held by such person on behalf of the Employer and not on the Company's behalf until otherwise paid or surrendered to the Company.

7. COMMENCEMENT, RENEWAL AND TERMINATION

7.1 The Cover shall be effective from the Effective Date as shown in the subject to payment by the Employer of the appropriate Premium, as agreed by the Company.

7.2 Unless otherwise agreed by the Company in writing, this Policy is issued for a Policy-Year and is renewable on the agreed date by the Employer upon payment of the renewal Premium. Renewal is subject to the terms and conditions of this Policy and the Benefits Tables applicable at the Renewal Date. The Company reserves the right to decline to renew this Policy. However, if the Company offers renewal terms in writing then this Policy shall automatically renew for a further Policy-Year on those renewal terms, unless the Employer shall have advised the Company in writing of its decision not to renew on such terms within

fourteen (14) days of the date such terms were sent to the Employer.

7.3 The Company reserves the right to immediately terminate this Policy, by giving a written notice, if

(i) any part of the Premium remains unpaid for more than twenty-eight (28) days after it has become due and payable (whether or not this has been paid to any intermediary or agent that is not directly employed by the Company); or
(ii) the Employer has misled the Company in any way; or
(iii) there has been a material breach by the Employer of any of the terms of this Policy.

7.4 In the event that this Policy is terminated by the Company in accordance with Clause 7.3 above, the Company shall (where applicable) undertake any Premium reconciliation as detailed in Schedule. The Company may, at its discretion, charge an administration fee.

7.5 Any termination of this Policy shall be without prejudice to any accrued rights and responsibilities of both the Company and the Employer in respect of the period for which the Premium has been paid.

8. ADMINISTRATION

8.1 The Employer undertakes to inform all of its Employees of all of the terms and conditions of this Policy, including the attached Schedules, issued by the Company or any notices issued by the Company relating to the Cover.

8.2 The Employer hereby undertakes to advise all of its Employees immediately if this Policy will not be renewed or will be or is terminated for whatever reason.

8.3 The Employer hereby undertakes to indemnify the Company against any and all costs, loses and expenses incurred with respect to that part of any Claim by an Employee that is not covered by this Policy, be it on account of a Deductible or Co-insurance payable by the Employee, or due to the Policy limit being exhausted, or due to the application of a Policy exclusion or due to any other reason.

8.4 The Employer hereby undertakes to indemnify the Company from and against any and all costs, losses and expenses incurred by the Company as a consequence of any failure by the Employer to discharge its responsibilities under this Policy.

8.5 The Employer shall designate a person as a scheme administrator to administer this Policy in accordance with its terms and any guidance issued by the Company, from time to time, and shall notify the Company, in writing, of any change in such designated person.

8.6 Where agreed the Employer shall designate verifying officers to verify in writing that all Claims for benefits are for the Employees and/or their Dependents covered by this Policy. The Employer shall notify the Company in writing of any change in the designated Verifying Officers.

8.7 The Employer shall advise the Company immediately if it goes into liquidation or is in the process of being dissolved (except in respect of a merger, acquisition or consolidation, where the resulting entity assumes all of the obligations of the Employer under this Policy) or if an administrator or receiver or an administrative receiver is appointed in respect of all or any part of the business or assets of the Employer.

9. GOVERNING LAW

This Policy shall be governed by and construed in accordance with the laws of the Islamic Republic of Pakistan.

10. ARBITRATION

10.1 The Company will consider all Claims fairly and in line with the terms and conditions of this Policy. In case of a dispute in respect of any Claim, the Company and the Employer will settle such dispute amicably.

10.2 All disputes that cannot be settled amicably shall be referred to arbitration conducted by arbitrators appointed in accordance with the Arbitration Act, 1940 and obtaining an award shall be a condition precedent to liability of the Company or any right of action against the Company.

11. HOLD HARMLESS AGREEMENT

The Employer shall reimburse the Company within fifteen (15) days of the Company's demand for any medical expenses incurred on account of the following:

11.1 Any unauthorised use of the Company's credit letter or membership card following the termination of individual Cover of any Employee or Dependent. It shall be the Employer's responsibility to gather and return credit letters or membership cards to the Company immediately upon termination of any individual Cover.

11.2 Any charges incurred in connection with any Claim in excess of the limits provided to any Insured Person by the Company.

11.3 Any ongoing Treatment of an Insured Person incurred after the termination of his / her individual Cover or where this Policy is not renewed, after the termination of this Policy.

11.4 Any Benefits not covered by the terms of this Policy.

12. ENDORSEMENTS

Any variations to this Policy or any of its attached Schedules are shown as Endorsements and will take precedence over any terms and conditions appearing elsewhere in this Policy.

AUTHORISED SIGNATORY

For and on behalf of IGI General Insurance Limited

(Date_____)

AUTHORISED SIGNATORY

For and on behalf of Lahore University of Management Sciences (Lums)

(Date_____)

TERMS AND CONDITIONS

INTRODUCTION

Certain words have been used in this Policy. These have the same meaning wherever they are used and the meanings of these words are defined below in Section 2, DEFINITIONS.

1. GENERAL CONDITION

1.1 Information relating to this Policy.

The Employer shall give the Company all such information as is requested by the Company, insofar as such information is relevant to the insurance being provided or to be provided in connection with this Policy.

1.2 Application for enrolment under this Policy.

Enrolment under this Policy must be made pursuant to the Application, by all eligible Employees who are Residents of Pakistan.

1.3 Refusals or Acceptance of Application.

The Company reserves the right to refuse any Employee's application without giving any reason or to accept the application (for membership) on any special terms which the Company may require.

1.4 Evidence of Age.

The Company reserves the right at any time to request evidence of the age of any Insured Member or of any person who has applied to join this Policy.

2. DEFINITIONS

Whenever the following words are used in this Policy, they shall have the meanings, which are given to them below, wherever they occur:

2.01 "Accident" means a circumstance that resulted in an injury caused solely and directly from unexpected, external, violent and visible means and does not include Illness or any naturally occurring medical condition or degenerative process.

2.02 "Accidental Bodily Injury" means physical injury caused by an accident which
a) is sustained by an insured person during the period of insurance,
b) occasions the necessity for the insured person to receive in-patient medical care or attendance at a hospital.

2.03 "Anaesthetist" means a Physician licensed to conduct general anaesthesia procedures.

2.04 "Application" means the Company's standard application form.

2.05 "Benefits" mean the amount of money that may be payable in respect of any Claim. The maximum Benefits are shown in the Benefits Table of schedule.

2.06 "Benefits Table" means a list stipulating the Overall Limit and the limits available for each benefit offered under this Policy.

2.07 "Claim" means the Benefits that the Insured Member asks the Company to pay in respect of an episode of Treatment.

2.08 "Claim Form" means the Company's standard claim form.

2.09 "Co-Insurance" means the proportion of the cost of each Claim or course of Treatment that is not covered by this Policy and for which the Insured Member or Employer must contribute. The Co-Insurance proportion, if any, is stated on the Benefits Table.

2.10 "Confinement" means the period during which an Insured Member is registered as a paying bed-patient in a hospital. Successive periods of hospital confinement, due to the same or related causes, not separated by more than ninety (90) days and without resumption of full normal work activities for that period shall, for the purposes of evaluating a claim under this policy, be considered to constitute one continuous period of hospital confinement and benefits only upto one ailment limit will be payable. This is applicable for Per Confinement/Per Ailment Policy.

2.11 "Day-care Treatment" means Treatment at a Hospital, Out-Patient clinic or other facility which is appropriate for the medical services provided, where the Insured Member is admitted to a Hospital bed but does not stay overnight. Expenses incurred for Treatment at the Outpatient or emergency ward of the Hospital are not considered "Day-care Treatment".

2.12 "Deductible" means the first part of the cost of a claim or series of claims expressed in terms of an amount that is not covered by this Policy and for which the Insured Member or Employer must contribute. The deductible amount if any is stated in Schedule.

2.13 "Dependents" means

a) the legal spouse of an employee (other than a legally separated spouse) living with the employee in a legally recognized husband and wife relationship and who is registered as such in the records of the Assured;
b) (i) an employee's unmarried child or step-child or legally adopted child upto the age of eighteen years living permanently in the employee's house and or is attending an educational institution and is registered as a Dependent of the employee in the records of the Assured;
(ii) an employee's unmarried child or step-child or legally adopted child over the age of eighteen but not having attained the age of twenty-five, if attending full-time college or university and satisfying the conditions (except for age) set forth in definition 2.13 (b) (i) above.
(iii) a Dependent daughter of a working employee till she gets married or is employed. Divorced/separated/widowed daughters' Dependent on the employee are also insured without any age limit.
c) parents of an insured employee provided they are fully Dependent on the insured employee.

2.14 "Disability" means any Illness or Injury.

2.15 "Effective Date" means the date of commencement of Cover as shown on The Schedule.

2.16 "Eligible Expenses" means those charges for Treatment that are payable by the Company and are:
2.16.1 reasonable and Customary;
2.16.2 medically Necessary;
2.16.3 within Policy Coverage and Limits; and
2.16.4 not excluded under any of the Terms and Conditions of the Policy.

2.17 "Emergency" means a health condition resulting from sudden illness or injury raising a professional concern that there may be a significant medical problem jeopardizing the Insured Member's life and necessitating Treatment which must not be delayed and which requires confinement to a hospital emergency facility.

2.18 "Employee" means any person legally and gainfully employed and compensated by the Employer on a continuous, permanent, full-time basis in the country in which this Policy was issued.

2.19 "Endorsement" means any variation to this Policy or any of its attached Schedules, including a replacement of any Schedule.

2.20 "Geographical Area" means the geographical limitation as stated in the Benefits Table.

2.21 "Health Card" means a card issued by the Company for the purposes of providing information to the Network Hospital regarding the Employee's certificate number, the Policy under which he is covered, his Dependents and Benefits available to the Employee and his Dependent's under the Policy.

2.22 "Hospital" means any institution that is:

2.22.1 licensed in accordance with the applicable laws of the jurisdiction in which it is located.

2.22.2 primarily engaged in providing, for compensation from its patients, diagnostic, medical and surgical facilities for the care and Treatment of injured or sick persons,

2.22.3 has 24 hours-a-day nursing service by registered graduate nurses under the permanent supervision of the Physician in charge,

2.22.4 maintains In-Patient facilities, and

2.22.5 maintains a daily medical record for each of its patients, which is accessible to the medical director of the Company.

2.22.6 A Hospital, despite any similarities with the above description, does not include any institution, which is primarily a rest or convalescent facility, a place of custodial care, a facility for the aged, alcoholics or drug addicts or for the Treatment of mental disorders, or a nursing home.

2.23 "Hospitalisation" means an insured person's stay in hospital for a minimum period of 24 hours for either necessary medical treatment of any disease, sickness or accidental bodily injury or treatment admissible in terms of this policy.

2.24 "Illness" means any physical condition marked by a pathological deviation from the normal state of health not otherwise specifically excluded by this policy, which

a) is sustained during the period of insurance and
b) occasions the necessity for the insured person to receive in-patient medical care and attendance at a hospital.

2.25 "Insured Member" means an Employee or Dependent who has fulfilled all of the eligibility conditions and is included under this Policy.

2.26 "Medically Necessary" means Treatment, services or supplies, as provided by a Hospital, Physician, registered Nurse or other provider required to identify or treat an Insured Member's Disability, which are:

2.26.1 consistent with customary allopathic medical Treatment for the Insured Member's symptoms, diagnosis or Disability;

2.26.2 appropriate with regard to the standards of good medical practice;

2.26.3 not solely for the convenience of the Insured Member or the benefit of the Physician, the Hospital or any other provider of Health Care; and

2.26.4 performed in the most reasonable and customary manner and setting that can safely be provided to the Insured Member.

2.27 "Network Hospital" means a hospital approved and identified as such by the Company for the purposes of providing Treatment, subject to the terms of this Policy, to its Insured Members.

2.28 "Non-network Hospital" means any hospital other than a Network Hospital.

2.29 "Out-Patient" means receiving Treatment at a Hospital, Outpatient clinic, Physician's consulting rooms or the residence of the Insured Member, where the Insured Member is not admitted to a Hospital bed as an In-Patient or Day-care patient.

2.30 "Overall Limit" means the total aggregate Benefits that the Insured Member may Claim in any Policy-Year, as shown in the Benefits Table.

2.31 "Physician" is an individual legally licensed to operate in the Geographical Area of his/her practice, is qualified by a degree acceptable to and recognized by the Government of Pakistan and is other than the Insured Member, who:

a) in the case of a Surgeon, Specialist, or Anaesthetist, is recognised as qualified to treat the type of Injury or Illness for which the Claim is made and for which Treatment is being provided;
b) is practicing within the scope of his/her licensing and training;
c) is not related by blood or marriage to the Insured Member, to whom Treatment is being provided; and
d) is not an Employee of or connected in any way to the Employer.

2.32 "Plan" means any one of the medical insurance schemes provided by the Company.

2.33 "Policy" means this agreement including its Schedules and Claims procedure, along with the Application and any Claim Form.

2.34 "Policy-Year" means twelve (12) calendar months from the Effective Date of this Policy or from the Renewal Date.

2.35 "Pre-Existing Medical Condition" means any Disability for which the Insured Member has received Treatment, medication or advice, or of which the Insured Member was aware or could be expected to be aware prior to joining the Plan.

2.36 "Premium" means the amount of money payable to the Company for the Insured Members to join and belong to a Plan.

2.37 "Reasonable and Customary Charges" means charges for medical Treatment to the extent that they do not exceed the general level of charges being made by other facilities, or Physicians of similar training and standing in the locality where the charges are incurred when giving like or comparable Treatment, to individuals of the same sex and of comparable age, for a similar Disability.

2.38 "Renewal Date" means the anniversary of when this Policy began, unless the Company has agreed any other date in writing.

2.39 "Resident of Pakistan" means a person that is normally living in Pakistan and who spends a total of at least nine (9) months of the Policy-Year in Pakistan.

2.40 "Schedule" means any of the schedules attached to this Policy.

2.41 "Specialist" means a Physician specializing in a particular area of medicine.

2.42 "Surgeon" means a Physician licensed to conduct surgical operations.

2.43 "Treatment" means a surgical procedure or medical intervention or any necessary investigations to cure a Disability.

2.44 "Usual Country of Residence" means the country in which the Insured Member is usually living in at the time of commencement of his cover and which is declared on the Application. Unless otherwise allowed for, in writing, the Usual Country of Residence for all Insured Members must be Pakistan.

In this Policy, terms denominated in the singular shall include the plural, and masculine terms shall include the feminine, when the context requires.

3. BENEFITS

3.1 Payment of Benefits

3.1.1 The Company's liability is subject to the limits and sub-limits indicated on the Benefits Table as applying to each item or type of cover provided after allowing, where applicable, for the Insured Member's contribution by way of any Co-Insurance or Deductible. Where the Hospitalization Benefit limits are expressed in terms of "per annum", the Hospitalization Limit stated in the Benefits Table shall mean the maximum amount recoverable under this Policy by an Insured Member for that benefit during any Policy-Year. However, where the Hospitalization Benefit limits are expressed in terms of "per ailment", then no such overall limit shall apply to the maximum amount recoverable under this Policy by any one person for that benefit during any Policy-year. However, the

per ailment limit shall define the maximum amount recoverable with respect to Treatment during any one Confinement and the limit would only be refreshed it either the confinements are separated by 90 (ninety) days; or successive confinements are due to different ailments.

3.1.2 The Benefits under this Policy are always subject to the terms and provisions of this Policy and to the limits and sub-limits indicated on the Benefits Table.

3.1.3 Satisfactory proof of Claim must be submitted in all cases and the Company may use an independent administrator to settle Claims on its behalf.

3.1.4 All charges must be necessarily incurred and be wholly and exclusively for the purpose of Treatment that is Medically Necessary, as determined by the Company and whose decision in this regard shall be binding.

3.2 Summary of Benefits

Hospitalization Benefits / Inpatient Medical Cover

These include surgical and miscellaneous hospital expenses (non-maternity) described below:

1) Daily Room and Board Charges

The Company will pay the charges actually incurred for the eligible class of Hospital Accommodation (and patient meals where applicable) for In-Patient Treatment of a covered Disability but not more than the maximum amount per day as set forth in the Benefits Table.

2) Intensive Care Unit (ICU) Charges

If whilst being confined to a Hospital for In-Patient Treatment and on the recommendation of a Physician, an Insured Member needs to be admitted to the intensive care unit (or another unit for a similar purposes however denominated) the Company will pay the charges actually incurred for the Insured Member's accommodation in the intensive care unit, but for not more than the maximum number of days for each Policy-Year as set forth in the Benefits Table.

3) Physician's Visit (In-Patient) Charges

The charges for professional attendance and Treatment by a Physician while the Insured Member is in Hospital as an In-Patient.

4) Specialist Consultation (In-Patient) Charges

The charges for professional attendance and Treatment by a Specialist, upon the recommendation of a Physician, while the Insured Member is in

Hospital as an In-Patient.

5) Surgical Operation Charges

The Benefits payable if a surgical operation is performed on the Insured Member. These charges can be for:

a) the charges made by a Surgeon in connection with the surgical operation, including pre-operative investigations and preparation of the Insured Member, the operative procedure and the post-operative care rendered by the Surgeon while the Insured Member is in Hospital .
b) the charges made by an Anaesthetist in connection with the surgical operation or examination requiring general anaesthesia including pre-operative and post-operative visits, the administration of the anaesthesia and the administration of fluids and/or blood incidental to the anaesthesia or surgery;
c) use of the operating theatre, Treatment room and equipment; and
d) such other charges approved in writing by the Company.

6) Miscellaneous Hospital Expenses

The Benefits available if an Insured Member is confined in a Hospital for In-Patient Treatment:

a) drugs, dressings and medicines prescribed by the attending Physician;
b) laboratory examinations and other diagnostic procedures;
c) physiotherapy;
d) intravenous injections and solutions;
e) administration of blood and blood plasma, including the cost of blood and blood plasma and any fluids administered during surgery;
f) general nursing services; and
g) such other charges approved in writing by the Company.

7) Day-care Surgery Charges

The total of the Day-care Treatment charges incurred for and in relation with a surgical procedure that is performed without the Insured Member being confined as an In-Patient, expenses incurred for treatment at the out patient or emergency ward of a hospital are not considered ‘Day care surgery’.

8) Pre-admission and Post-hospitalization Benefits

8.1 These are charges (Physician/ surgeon fee, medicines and diagnostics in out patient settings) connected to a period of

Hospitalisation and are for the same or a related Disability.

8.2 Pre-admission diagnostic testing charges i.e. the expenses for diagnostic and laboratory examinations on the basis of which admission of the insured person in hospital is considered necessary and admission actually occurs.

8.3 Post-hospitalisation consultation charges are the expenses for consultation with the same physician or surgeon that treated the insured person during hospitalisation, including cost of medicines.

8.4 Pre-admission diagnostic testing and post-hospitalisation consultation expenses are restricted by the following conditions.

a) Admission to a hospital as an in-patient or day-care patient must take place while this policy is in force.

b) Pre-admission diagnostic testing charges must be incurred after the effective date of this policy and must immediately precede admission in hospital by no more than thirty days and

c) Post-hospitalisation consultation charges must be incurred immediately following discharge from the hospital and within thirty days.

9) Local Ambulance Cover

These are the reasonable and customary expenses incurred for the use of a road ambulance for the transportation of the Insured Member to or between Hospitals within city in the course of a medical emergency.

10) Emergency Accidental Outpatient Cover

These are the expenses that relates to emergency Treatment of an Accident, undertaken in an emergency room or casualty ward of a Hospital or any other facility that is appropriate for the medical services provided. Treatment must be taken within forty-eight (48) hours of the Accident in order to be eligible for cover.

11) Emergency Accidental Dental Treatment

These are the expenses that relate to the emergency Treatment necessary to relieve pain only as the result of an Accident and for which Treatment is provided within forty-eight (48) hours following the Accident.

12) Specialized Investigations Outpatient Cover

These are the expenses that are Medically Necessary to arrive at a diagnosis or to facilitate Treatment and only if required by a Physician or

Specialist, this Policy will pay for the following investigative procedures:

a) Magnetic Resonance Imaging (MRI)
b) Computed Tomography (CT) Scans
c) Endoscopy

Prior approval from the Company will be necessary.

13) Discretionary Benefit Option

Any expenses that are not covered under the normal policy terms and conditions can be paid through exercising this option, when offered up to the assigned limit as mentioned in the BENEFIT TABLE. The payment has to be authorized by the authorized representative of the Employer.
The limit stated in the Benefits Table for Hospitalisation Benefits is the overall limit applicable to the sum of all benefits claimed under the Hospitalisation Benefits section of this Policy.

14) Extended Medical Cover / Major Medical Cover / Additional Hospitalisation

This includes all the surgical and miscellaneous hospital expenses covered under Hospitalization Benefit as mentioned above, provided the insured has not partially/completely utilized his Extended/Major Medical limit in any prior policy years. Availing this benefit once will make the insured person ineligible for such benefits for all following policy years.

Expenses incurred on maternity / treatment not requiring hospital admission are not covered under this or inpatient medical cover benefit.

15) Dread Disease Cover / Critical Illness Cover

This includes Coverage for specified ailments of benefits and offered in lieu of extended medical cover, when desired. Availing this benefit once will make the insured person ineligible for such benefits for all following policy years.

Only following would be the illnesses covered for inpatient treatment under the 'Dread Disease Cover / Critical Illness Cover'. Any ailment not falling in the below mentioned list would not be covered from this cover and the total liability as such would remain limited to the basic inpatient medical cover only.

1) Myocardical Infarction (Heart Attack)
2) Coronary Artery Disease Requiring Surgery
3) Stroke
4) Cancer

5) Major Organ Transplant
6) Multiple Sclerosis
7) Hepatitis B & C (Inpatient Treatment only)
8) Severe Burns (3rd Degree only)
9) Aortic Aneurysms
10) Rheumatic Heart Disease
11) Organ Failure (without transplantation)
12) Liver Cirrhosis
13) Meningitis
14) Paralysis
15) Parkinson's Disease
16) Muscular Dystrophy
17) Alzheimer's Disease
18) Myasthenia Gravis
19) Syringomyelia

4. SPECIFIC TERMS AND CONDITIONS

4.1 Liability

4.1.1 The company's liability shall stand discharged upon expiry of the policy and any claims incurred during the policy period shall only be attended if submitted during 30 days following policy period, irrespective of policy renewal or termination.

4.1.2 In the event of termination or non-renewal of this Policy, the Company will only be liable to pay Benefits with respect to expenses incurred up to the expiry of this Policy, even if the Insured Person was first admitted to Hospital while this Policy had been in force.

4.2 Discharge of Liability

Benefits are payable either to the Insured Member, the Employer or to the providers of covered medical or other services whose official receipt shall be a valid discharge of the Company's liability to pay in respect thereof. Only Reasonable and Customary Charges will be reimbursed.

4.3 Other Insurance

If the Insured Member has any other insurance in force or is entitled to indemnity from any other source in respect of the same Accident, Illness or expense, this Policy will only provide compensation on a proportionate basis. The Company has full rights of subrogation and may undertake proceedings in the Insured Member's name, but at the Company's expense, to recover for the Company's benefit from the other insurance provider, the amount of any payment made under this Policy or to say as;

The benefits of this policy will not duplicate the benefits of any other group medical plan or statutory plan for which any covered person may be eligible. When any insured person is also covered by any such duplicate benefits, the benefits under this policy will be reduced to an amount which, when added to such duplicate benefits, will equal 100% of the benefits provided by this policy.

4.4 Hospital Admission Procedure

4.4.1 In any non-Emergency case, Treatment may only be sought at a Network Hospital. However, in cities within Pakistan where there is no Network Hospital, the Employee may avail Treatment at a Non-Network Hospital.
In emergency cases – where the life of an insured patient may be endangered due to delay - treatment may be sought at any nearest hospital.

4.4.2 In Emergency and non-Emergency cases, the Employee should present his Health Card to the Network Hospital at the time of admission and show proof of identification of the person for whom Treatment is being sought. The Company shall pay all Eligible Expenses directly to the Network Hospital. In respect of non-Eligible Expenses the Network Hospital may require the Employee to place a deposit with the Network Hospital. The Employee shall pay all other expenses directly to the Hospital before the patient is discharged.

4.4.3 If an insured person accommodates in a room higher than his/her respective room rent limit, credit for hospitalisation is not allowed; any difference in room charges alongwith difference in charges for services (consultant, procedure, operation, investigations) would be borne by the insured patient and settled with the panel hospital directly; treatment expenses being eligible only as per room rent entitlement irrespective of the hospitalisation limits and could be claimed in reimbursement.

4.5 Circumcision Benefit (including its complications)

4.5.1 Payable only from the available maternity limit up till the pre-agreed limit.

4.5.2 Payable once to a child born during policy period.

4.6 Reimbursement of Claims at Non-Network Hospitals

4.6.1 In the event the Insured Member obtains Treatment at a Non-Network Hospital, the Company reserves the right to limit the reimbursement for the Medically Necessary Treatment to only the Reasonable and Customary Charges for similar treatment at one of the network hospitals as per insured's entitlement.

4.6.2 In non-emergency cases if an insured person wishes to be hospitalised in a

non-network hospital, the Company's prior written approval would be necessary. The bill will then be reimbursed according to the rates/charges of the Company's network hospitals in the same city/town. In such cases the Company must be informed at least three days prior to hospitalisation.

4.6.3 Reimbursement of claims for eligible medical expenses incurred outside Pakistan shall be made on the basis of what it would cost for a similar procedure to be carried out in Pakistan and the claim will be settled in Pak-Rupees.

4.6.4 In emergency/non-emergency cases, if an insured person is hospitalized at a network hospital, without producing our health card, the bill will then be reimbursed according to rates/charges agreed for such treatment by us with the same network hospital.

4.6.5 In emergency/non-emergency (hospitalization/maternity) cases, if a patient prefers being treated at network hospital through a consultant of his/her own choice, then any such charges incurred for being consultant's private patient would be payable only after comparison with our agreed rates for the same at network hospital

4.6.6 For all claims involving Treatment at Non-Network Hospitals, a Co-insurance percentage shall apply, if specified in the Benefits Table.

4.7 Examinations and Further Information

The Company shall have the right and opportunity through its medical representatives to examine the Insured Member, at its own expense, whenever and so often as it may reasonably require in relation to a Claim.
If in the Company's opinion there is any cause to doubt the Claim of the Insured Member pursuant to the Company's own examination as stipulated above, the Company shall have the right to ask for any further information in order to establish the eligibility of a Claim. Such information must be provided, and shall be at the expense of the Insured Member.

4.8 Residency

The Insured Members must be Residents of Pakistan. However, if an Insured Member is not a Resident of Pakistan, the Company at all times reserves the right to cover such Employees and/or their Dependents on terms and conditions that it considers appropriate or to decline to cover such Employees and/or their Dependents under this Policy. If the Company were to extend coverage to a non-Resident of Pakistan, it must be informed of the residence of such Insured Members.

4.9 Fraud

If any Claim shall in any respect be false or fraudulent or if fraudulent means or

devices are used by the Employee or anyone acting on the Employee's behalf to obtain a Benefit hereunder, then the Company shall be entitled to any one or all of the following at the Company's discretion:

a) refuse to pay any Benefits in relation to the Claim;
b) to cancel the cover for the Employee and his Dependent immediately retaining all further Benefits and Premiums;
c) refuse to renew the cover for the Employee and his Dependents; and/or
d) recover any monies already paid to the Employee or on his behalf.

4.10 General Terms

4.10.1 The Company may alter this Policy or any of the attached Schedules from time to time but no alteration shall take effect until the next annual renewal of this Policy. The Company shall notify such changes to the Employer in writing and, where appropriate, shall issue replacement Schedules.

4.10.2 The Company reserves the right to revise or cancel this Policy with effect from any Renewal Date.

4.10.3 The company would approve maternity cases upto normal delivery limit only whenever elective caesarean section is performed and in such cases under no circumstances would limit of caesarean section is offered which is reserved for either emergency caesarean sections or child births which could not be carried out through normal delivery procedures.

4.10.4 Pre-existing conditions would only be accepted on roll-over cases if such conditions are declared and accepted for insurance by the Company in writing and that too only for employees and Dependents who exist in the policy at inception. Pricing, if to attend such conditions for new entrants, would be dealt on case to case basis on terms such as charging of 75% premiums on expected/incurred claims amount or on normal delivery/caesarean section limits for maternity cases, whatever is imminent.

4.10.5 The company's policy for premium refund while processing batch deletions of insured lives (more than 10 percent of the group size) would take into account the claims ratio on earned premium till date. If the incurred claims ratio exceeds the earned premium, no refund could be offered unless the position is otherwise at policy expiry, when the premium could be refunded on pro-rata basis from the date of deletion.

4.10.6 This Policy can only be varied in writing. No variation will be admitted unless it is in writing and signed on the Company's behalf by an authorised employee.

4.10.7 The Company will not allow any change in benefit during the policy period. Nevertheless, if there is change of category of the insured, the same would be executed upon receipt of relevant supporting evidence alongwith appropriate

premium difference. However, claims payment for existing medical conditions would be restricted to limits as per previous entitlements

4.10.8 Appropriate adjustments in premium shall be made for incoming and outgoing insured persons. For an incoming and outgoing insured person premium will be charged on prorate basis of the policy year in which he/she has added/deleted. However, if any claim is paid to the account of an outgoing insured person during the currency of the policy period then no premium refund will be allowed

4.10.9 The Assured shall send Health Cards of the respective employees to be deleted for the company to process deletion request and premium refund.

4.10.10 All information and evidence required by the Company shall be furnished without expense to the Company and in such form as the Company may require.

4.10.11 The Assured shall give immediate notice to the Company of any change in their business, trade or profession as described in the schedule of this policy.

4.10.12 Any notice to be sent under this Policy must be in writing and be sent by certified or registered mail or by registered courier or by facsimile transmission. A notice shall be considered to have been given, if sent by certified or registered mail or registered courier, on the day after it was posted or, if sent by facsimile machine, at the time of transmission to the Company or the Employer at the normal place of business or its registered office (if different).

4.10.13 The waiver by the Company of any provisions of this Policy or the introduction of any change in interpretation or practice of any terms and conditions of this Policy shall not prevent the subsequent enforcement of those provisions, terms or conditions and shall not be deemed to be a waiver of any similar provisions of this Policy or subsequent change in interpretation or practice of any terms or conditions of this Policy. If any notice is given to any Insured Members such notice may be given care of the Employer.

4.10.14 The payment of premium under this policy in installments as per mutually agreed frequency is hereby allowed on the condition that the outstanding payment would be made by the policyholder upon either as per the agreed schedule or the ratio of claims notified reaching 70 per cent of the premiums paid, whichever comes first; in order to avail uninterrupted claims settlement.

4.10.15 The Company shall, at any time by giving seven days' notice to the assured by registered letter at their address as last known to the Company, be at liberty to cancel this Policy, provided that the Company shall in that event on demand return to the Assured a proportionate part of the premium corresponding to the unexpired period of insurance.

4.10.16 The Company also reserves the right at any time to terminate the insurance

cover for any insured person, after giving notice to the Assured, if he or any member of his family covered by this contract has at any time:

a) misled the Company by a false statement or concealment;
b) agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Company's detriment;
c) failed to act with the utmost good faith

4.10.17 This policy and Schedule and any endorsement(s) hereon shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this policy or of the Schedule or of the endorsement(s) shall bear such specific meaning wherever they may appear.

4.10.18 No alteration in the terms of this Policy, or any endorsement hereon, will be held valid unless the same is signed by an authorized representative of the Company.

4.10.19 The Company shall not be affected by notice of any trust, charge, lien, assignment or any other dealing with this policy and the receipt of the assured or of any person or persons to whom any benefit is expressed to be payable hereunder, shall in all cases be effectual discharge of the Company's liability under this policy.

4.10.20 The due observance and fulfillment of the terms and conditions contained herein endorsed or otherwise expressed hereon by the Assured and Insured Persons in so far as they relate to anything to be done or complied with by them and the truth of the statements made by the Assured shall be conditions precedent to liability of the Company to make any payment under this policy.

5. EXCLUSIONS

The following treatment, items, conditions, activities and their related or consequential expenses are excluded from this Policy unless cover is specifically provided. The Company shall not be liable for:

5.1 Any pre-existing conditions, unless fully disclosed prior to the date of eligibility for insurance and coverage approved by the Company in writing.

5.2 Any charges in respect of the donor for organ transplant Claims.

5.3 Services or Treatment in any spa, hydro clinic, sanatorium, nursing home or long term-care facility that is not a Hospital.

5.4 Routine medical examinations or check-ups including charges arising out of any Hospital confinement or admission primarily for diagnostic purposes unless specifically authorized by the Company, routine eye or ear examinations, vaccinations, medical certificates, examination for employment or travel, spectacles, contact lenses, hearing aids and any Treatment that is not considered Medically Necessary.

5.5 Any In-Patient dental treatment, X-Rays, extractions or fillings unless necessitated due to accidental injury occurring while the insured was covered.

5.6 Any Out-Patient Treatment, except that arising out of an Accident, unless, covered under a separate optional extension under this policy.

5.7 Cost of medicines for cosmetic treatment and/or treatment of falling hair or hair implant or plastic surgery, unless it is re-constructive surgery necessitated by an Injury that occurred during the period whilst the Insured Member was covered under this Policy and subject to the limits and sub-limits stated in the Benefits Table.

5.8 Pregnancy and complications thereof, childbirth (including surgical delivery), miscarriage, abortion and/or any related prenatal or postnatal care unless covered by a separate rider under this Policy.

5.9 Tests or Treatment relating to fertility, infertility, impotence, contraception or sterilization and any complication relating thereto or hormone treatment and investigations.

5.10 Expenses directly or indirectly resulting from or consequent upon birth defects, congenital defects / illness and deformities (including physical and mental defects) of any nature whatsoever.

5.11 Prostheses, corrective devices and medical appliances e.g eye glasses, contact lenses, hearing aids, and wheelchairs etc. which are not surgically required.

5.12 Psychotic, mental or nervous disorders (including any neuroses and their physiological or psychosomatic manifestations) or sexual reassignment (whether or not for psychological reasons) or emotional or psychological disturbance, anxiety, allergy or mental stress.

5.13 Experimental or unproven Treatment.

5.14 Self-inflicted Injury, attempted suicide, abuse of alcohol, drug addiction or abuse and Treatment of any sexually transmitted diseases.

5.15 Participation in or training for any dangerous or hazardous sport, mountaineering or rock climbing, pastime or competition or riding or driving in any form of race or competition or any professional sport.

5.16 Aviation other than as a fare-paying passenger of a recognized airline or charter service.

5.17 Treatment received in a location other than the Insured Member's Geographical Area of Coverage, as indicated in the Benefits table.

5.18 Injury or Treatment resulting from war, riots, invasion, act of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, mutiny, civil commotion assuming the proportions of or amounting to a popular uprising, military uprising, insurrection, rebellion, military or usurped power or any act of any person acting on or on behalf of or in connection with any organization actively directed towards the overthrow or to the influencing of any government or ruling body by force, terrorism or violence.

5.19 Injuries as a result of an illegal act other than a minor misdemeanor or minor delinquency by the Insured Member.

5.20 Ionizing radiation or contamination by radioactivity from any nuclear fuel or nuclear waste, from the process of nuclear fission or from any nuclear weapons material.

5.21 Any increase in the expenses incurred for Treatment on account of the Insured Member being admitted to a more expensive room than allowed by his Daily Room and Board Limit.

5.22 Acquired immune deficiency syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases caused by and or related to HIV virus unless covered under any endorsement.

5.23 Expenses incurred on account of:

- durable medical appliances (e.g. nebuliser)
- anorexia, obesity, weight reduction, insomnia;

- ovulation induction, invitro-fertilization (IVF);
- food supplements (e.g. vitamins), herbal medicines;
- preventive treatment and vaccinations/immunization, acupuncture;
- rest cures, sanitaria, custodian care of periods of quarantine or isolation.

5.24 Correction of refractive errors of the eye and procedures such as radial keratotomy and lasik/excimer laser or any treatment arising out of use of contact lenses.

5.25 Cost of limbs or prosthesis or supporting equipment for revival or correction of the function(s) of body.

5.26 Personal comfort items such as, charges for telephone, meals for other than the patient or other items not medically necessary.

5.27 Air ambulance or evacuation or repatriation expenses.

5.28 Radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

5.29 Naval or military or air force or police force operations planed or conducted against bandits, terrorist or other like elements.

5.30 Any expenses incurred on account of conservative treatment/management/ observation of patient or any kind of inpatient treatment which could generally be done on an outpatient basis or any hospital confinement primarily for diagnostic purposes at the Hospital/Clinic/Nursing-Home/Home/Maternity-Home unless authorized by the company in writing.

5.31 Any difference in expenses incurred on account of availing services of a consultant of own choice even at a network hospitals.

5.32 Treatment for injuries sustained as a result of participation by the Insured in an act which is illegally according to the laws of Pakistan.