Jubilee General Insurance Company Limited
2nd Floor, Jubilee Insurance House, I.I Chundrigar Road
P.O Box 4795, Karachi-74000, Pakistan
UAN: 111 654 111, Tel: (021) 32416022-26
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Parents Care Plus

PREAMBLE AND OPERATIVE CLAUSE

This Policy is granted by Jubilee General Insurance Company Ltd. (hereinafter called "the Company") to the person(s) described in the Policy Schedule as the Policy Owner(s) on the life of the person mentioned therein as the Life Assured.

The proposal, declaration(s), and any statement(s) made by the Policy Owner(s) and Life Assured in connection with this Policy shall be the basis of this contract, which provides that in consideration of receipt and realization by the Company of the Premium mentioned in the Benefit Schedule, the Company will pay to the Life Assured, Nominee(s), successor(s) or assignee(s) of the Policy Owner(s), the specified Benefit Assured on the happening of the event described in the Benefit Schedule as the Event Assured Against.

The liability of the Company is at all times subject to the Benefit Schedule, Standard Policy Conditions and any special conditions or endorsements issued by the Company and attached to this Policy, all of which are part of the contract evidenced by this Policy.

This is a digitally signed copy of the policy which may be verified for authenticity by logging on to our website https://online.jubileegeneral.com.pk/manage

(*) Jubilee General Insurance Company is registered and supervised by the Securities and Exchange Commission of Pakistan

Schedule of Benefits

	Silver	Gold	Platinum
Benefit Details			
Coverage Limit	Rs. 100,000	Rs. 250,000	Rs. 500,000
Room Financing per day	10,000	25,000	50,000
OPD	10,000	20,000	40,000
Effective IPD limit	80,000	205,000	410,000
ICU / Operation Theatre charges	Actual	Actual	Actual
bulance - per Hospitalization / per policy	3000	3000	3000
Pre Hospitalization	30 days	30 days	30 days
Post Hospitalization	30 days	30 days	30 days
Post Hospitalization – Nursing Care Benefit: PKR 20,000 / Year	The product also provides a nursing care benefit of PKR 20,000 in case of hospitalization due to paralysis, stroke or fracture and nursing care is advised by the attending physician. The benefit is payable once a year only.		
Day-Care Procedures & Specialized Investigations in outpatient setting including but not limited to: Dialysis, Cataract Surgery, MRI, CT Scan, Endoscopy, Thallium Scan, Angiography, and Treatment of Fracture. Emergency dental treatment due to accidental injuries within 48 hours (for pain relief only).	Covered	Covered	Covered
Pre-Existing Conditions & Congenital Anomalies Coverage *Pre-existing conditions are not covered during the first year for individuals aged 65 to 70.	1st year 10% of Annual Limit 2ndyear 20% of Annual Limit 3rd year 30% of Annual Limit 4th year & onward 50% of Annual Limit	1st year 10% of Annual Limit 2ndyear 20% of Annual Limit 3rd year 30% of Annual Limit 4th year & onward 50% of Annual Limit	1st year 10% of Annual Limit 2ndyear 20% of Annual Limit 3rd year 30% of Annual Limit 4th year & onward 50% of Annual Limit
International Medical Second Opinion (MSO) Benefit: International Medic al Second opinion from MediGuide International from some of the best hospitals across the world.	Covered	Covered	Covered
Online Doctor Consultation: Online Audio / Video consultation through our Partner	Covered	Covered	Covered

SECTION I

GENERAL POLICY TERMS ENTIRE CONTRACT

This policy, the application of the Policyholder, endorsements and riders, if any, and the list of Insured attached hereto, constitute the entire contract between the Company and the Policyholder.

ALTERATIONS TO THIS POLICY

The terms, conditions and benefits provided by this policy may be altered at any time by Company. All such alterations shall be communicated to the Policyholder in writing and deemed to be an endorsement of the policy and shall be binding on all Insured covered under the policy.

REQUIRED INFORMATION /CLERICAL ERRORS

The Policyholder shall furnish to the Company all information that may be required by the Company with regard to any matter pertaining to the policy. All documents and records that may have a bearing on the benefits or premium rates provided by this policy shall be open for inspection by the Company at all times during the continuance of this policy.

Neither clerical error, by the Policyholder or by the Company, in maintaining any records concerning the insurance hereunder, nor delays in compiling such records shall invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated, or establish any insurance not otherwise in existence, but upon discovery of such error or delay an equitable adjustment of premium shall be made.

REFUSALOR ACCEPTANCE OF APPLICATION

The Company reserves the right to refuse any application without giving any reason or to accept the application on any special terms which the Company may require.

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.

MISSTATEMENT OF FACTS

If relevant facts pertaining to any Insured concerned with insurance under this policy shall be found to have been misstated fraudulently, by the Policyholder, then insurance on the Insured shall be void able at the option of the Company. The C o m p a n y reserves the right to make adjustments in premium and/or amounts of insurance as the Company may consider appropriate, had the facts been declared correctly.

ELIGIBILITY

The Policyholder when applying for coverage may apply to cover himself/herself, his/her spouse and his/her Parents or Parents in Law.

Insurance for an eligible Policyholder shall commence under the provisions of this policy only if the Company approves his evidence of insurability. Such evidence shall be furnished, at no cost to the Company, through the Policyholder, in a form satisfactory to the Company. The eligible Insured should be Actively at Work and below the Maximum Eligibility Age.

AMOUNTS OF INSURANCE

The amounts of insurance for the benefits provided by this policy to each Insured person shall be determined in accordance with the plan of benefit stated in the Schedule of Benefits.

EFFECTIVE DATES OF INSURANCE

The effective date of a Policyholder's insurance will be t h e d a t e on w h i c h t h e C o m p a n y approves the Policyholders" evidence of insurability.

Notwithstanding the foregoing, neither initial insurance, nor any increase in insurance shall become effective on a date when a Policyholder is not Actively at Work because of a disability resulting from Sickness or Injury. In such case, the Company shall require the Policyholder to furnish evidence of insurability for himself in the manner aforementioned, after he returns back to Actively at Work status.

The effective date of initial insurance or the increase in insurance shall be determined by the Company on the basis of such evidence of insurability and, communicated to the Policyholder in writing.

TERMINATION OF AN INSURED'S INSURANCE

All insurance of any Insured under this policy shall cease at the earliest of the following times:

(1) Upon termination of this policy

(2) Upon t h e Insured at training t h e Maximum Eligibility Age.

(3) Upon any other date on which the Insured ceases to be eligible for insurance.

The Company also reserves the right at any time to terminate the insurance of any Insured after giving notice in writing to the Policyholder if he/she covered by this contract has at any time fraudulently:

(1) Misled the Company by miss-statement or concealment.

(2) Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Company's detriment.

(3) Failed to act with the utmost good faith.

PREMIUMS/RENEWALS

All Premiums are payable yearly in advance at the head office or the relevant branch of the Company. Failure to pay any premium on or before its due date shall constitute default hereunder.

The Policyholder shall also be responsible for the payment of the premium, The first premium is policy on the Policy Effective Date and will continue the policy for a term of twelve months.

Thereafter, at the consent of the company, the policy may be renewed every year on such terms and condition and on payment of such renewal premiums as the company may determine, the Company reserves the right to decline to renew the policy.

For renewals, t h e company is under no obligation to notify you of the renewal date of the policy, however a Grace Period of 30 days is permissible and the policy will be considered as continues.

For renewals received after the completion of 30 days Grace Period, a new application should be submitted the company and it would be processed as a NEW Business Proposal.

Free Look Period

Policy Holder has a period of 14 days from the date of receipt of the policy document to review the terms and conditions of this Policy. If Policy Holder has any objections to any of the terms and conditions, Policy Holder has the option of cancelling t h e Policy stating t h e reasons for cancellation. If Policy Holder has not made any claim during the Free look period, Policy Holder shall be entitled to refund of premium subject to, deduction of the Administrative charges and Government taxes expenses incurred by Company.

TERMINATION OF POLICY

The Policyholder may terminate this policy by giving to the Company written notice stating when, not less than 15 days after the date of such notice, such termination shall become effective.

Refund of premium in this case shall only be in case if no claims have been made under the policy and will be as per the following table:

Length Of Policy in force	Percentage of Premium Refund
Up to 01 month	70%
Up to 3 months	40%
Up to 6 months	20%
06 months above	Nil

The Company reserves the right to terminate the policy, by giving a 15 days written notice to the Policy holder, or add or alter or repeal the terms and conditions here for whatever reasons. In the event of the termination of this contract by the Company the premium shall be refunded for the unutilized period of the policy. There will be no refund if any claims have been made under the policy.

LATE SETTLEMENT OF CLAIMS:

When payment of a claim by the Company becomes due and the Policyholder has complied with all the requirements, including filing of complete papers, for claiming the payment and the Company fails to make a payment in 90 days from the date at which the payment becomes due or the date on which the Policyholder complies with the requirement, whichever is later, pay as liquidated damages a sum calculated in a manner specified below, as the payment so payable unless the Company proves that such failure was due to circumstances beyond its control.

CALCULATION OF LIQUIDATED DAMAGES:

The liquidated damages payable for the late settlement of claim shall be payable for the period for which the failure continues and shall be calculated as monthly rests at the rate of 5% higher than the prevailing base rate.

POLICYHOLDER'S OBLIGATIONS:

1. The Policyholder undertakes to reimburse the Company within 30 days for any expenses or loses incurred by the Company in respect of Treatments by covered Persons which were not covered by the terms and conditions of this Policy, including but not limited to payments in excess of the applicable benefit limits; payments in cases where a policy exclusion applies and payments incurred after the termination of a covered Person or termination of this Policy.
2. The Policyholder undertakes reimburse the Company for any expenses or losses incurred by the Company due to the failure by the Policyholder to discharge its responsibilities under the Policy, including any unauthorized use of the Company's Health Card.
3. The Policyholder will reimburse the Company for any benefit paid or expenses or losses incurred by the Company on account of any Pre- existing Condition beyond the extent which is covered under the policy.

FRAUD

If any claim shall be false or fraudulent in any respect, then the Company will be entitled to undertake any or all of the following actions:

1) Refuse to pay any benefits in relation to the Claim.

2) Cancel the Policy immediately, without returning the premium payments made.

3) Recover any monetary amounts already paid.

WAIVER OF CONTRACT PROVISIONS

The waiver by the Company of any provisions of this Policy or the introduction of any change in interpretation or practice of any terms or 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 change in interpretation or practice of any similar terms or conditions of this Policy.

TERRITORIAL LIMITS

This policy is meant to cover treatment within Pakistan.

ARBITRATION

Any difference which may arise between the Company and the Policyholder and cannot be settled amicably shall be settled by arbitration in accordance with the statutory provisions for the time being in force applicable thereto and the obtaining of an award shall be a condition precedent to any liability of the Company or any right of action against the Company.

APPLICABLE LAW

This P o l i c y , and all rights, obligations a n d liabilities arising hereunder, shall be governed and interpreted in accordance with the Laws of the Islamic Republic of Pakistan.

CUSTOMER SERVICE & GRIEVANCES REDDRESSAL:

i. In case of any query or complaint/grievance, Policy Holder may approach office at the following address:

Health Insurance Administration Office 2nd Floor, PNSC Building, Lalazar, M.T Khan Road, Karachi 74000
Phone: 021-3811 4000, 021-3565 7885-6
Facsimile: 021-35611349
E-mail: customer.services@jubileehealth.com

ii. In case Policy Holder is not satisfied with the decision of the above office, or have not Received any response within 10 days, then Policy Holder may contact the following official for Resolution:

Jubilee General Insurance Company Limited 2nd Floor, Jubilee Insurance House, I.I. Chundrigar Road, P.O.BOX 4795, Karachi 74000, Pakistan
UAN: (021) 111-654-111
Tel: 021- 38142900
Fax: 021- 32416728, 32438738
Email: Info@jubileegeneral.com.pk
Website: www.jubileegeneral.com.pk

SECTION II

BENEFITS–TERMS, PROVISIONS & EXCLUSIONS

HOSPITAL EXPENSE BENEFITS

Subject to the expense limits under Hospitalization Expense Benefits as stated in the Schedule of Benefits, and other terms and conditions of the policy, the Company shall pay for Reasonable and Customary charges for all Medically Necessary Treatment, provided on the advice of a Physician to the Insured during Hospital Confinement OR if the Insured undergoes a Surgical Operation without being registered as a bed patient. The following benefits are payable:

1. **Daily Room Benefits**: The room charges per day, as per the sub limit specified in the Schedule Of Benefits.
2. **Intensive Care Unit Charges:** The charges per day for ICU or another unit for similar purpose, as per the sub limit specified in the Schedule Of Benefits.
3. **Hospital Miscellaneous Expenses:** Expenses, which are made for the following:
   a) Prescribed medical supplies and services (except room charges and charges arising from special nursing services),
   b) Physicians" and surgeons' visits,
   c) Laboratory tests and X-ray examinations,
   d) Operation theatre charges,
   e) Anesthesia and administration thereof,
   f) Blood transfusions, including cost of blood, provided, however, that if the Insured is confined as a registered bed-patient, benefits shall be paid hereunder only for charges incurred during the period for which benefits are payable under (1) above,
   g) Physiotherapy.
   h) Ventilator and allied services.
4. **Surgical Expenses:** Fee for any Surgical Operation, performed by a licensed Physician/ Surgeon.
5. **Day Care Surgery Expenses:** Charges incurred for surgical operations on a pre-planned basis without an overnight stay in a hospital.
6. **Pre and Post Hospitalization Expenses:** Reasonable and Customary charges for all Medically Necessary Out-Patient Treatment, which are directly related to the cause of hospitalization, provided on the advice of a Physician to the Insured, occurring while the Insured is covered under the policy. The benefit is restricted to the number of days before and after the hospitalization and the sub limit for such expenses,as specified in the Schedule of Benefits.The following benefits are payable:
   - Physician's fee.
   - Cost of prescribed medicines.
   - Cost of Laboratory Tests.
   - Dressing Charges, stitch removal.
   - Nursing Care Benefit – Post Hospitalization Only

Expenses for any Pre/Post hospitalization Outpatient Treatment related to pregnancy are excluded from the scope of this benefit

7. **Ambulance Service Expenses:** Expenses incurred for the use of a road ambulance for the transportation of the Insured to or between Hospitals within the same city in the course of an Emergency. The maximum amount payable for such expenses shall be as per the sub limit, specified in the Schedule Of Benefits.
8. **Medical Second Opinion (MSO) Benefit:** International Medical Second opinion from Mediguide International for more than 100 top hospitals across the world
9. **Online Doctor's Consultation Benefit:** Online audio/video doctor consultation through our partner via their mobile app.

PROCEDURE OF OBTAINING BENEFIT

For inpatient benefits only, the Company will arrange the Treatment on credit/Cashless basis and has made credit arrangements with a number of Approved Hospitals, a list of which is attached to the policy.

<u>This credit arrangement is subject to a prior approval from the Company as per the following procedure:</u>

In case Hospital Confinement is advised by a Physician, the Policyholder must first seek approval, from the Company at least 03 days in advance, by submitting a duly filled prior approval form with details of the Treatment / procedures to be carried out. Once the

Treatment is approved, the Company would then coordinate with the Panel Hospital to arrange credit for the approved Eligible Expenses.

Each Policyholder will be issued with a health card, outlining briefly the services covered under the policy along with the details of the Policyholder.

At the time of commencement of Hospital Confinement at a Panel Hospital, the Policyholder should present his health card to the Panel Hospital and show proof of identification of him in form of national identity card. All eligible expenses (as defined in this Policy) will be settled directly by the Company to the Panel Hospital, in line with the approval. The Policyholder shall pay all expenses other than the eligible expenses directly to the Hospital before discharge of the Covered Insured

HOSPITAL CONFINEMENT IN A NON-PANEL HOSPITAL

The Policyholder is not allowed to seek Treatment from a Non-Panel Hospital.

NOTIFICATION IN CASE OF AN EMERGENCY HOSPITAL CONFINEMENT

In all Emergency Hospital Confinement(s), in a panel hospital the Company should be intimated within 24 hours of such Hospital Confinement. Intimation to the Company shall mean intimation given by or on behalf of the Insured to the Company at its Head Office, with information sufficient to identify the Insured, the Hospital and the Physician.

In case any of the above procedures are not followed, the Company reserves the right to either negate or reduce the benefit amount for such Hospital Confinement(s).

Medical Second Opinion (MSO): Utilization Procedure

- Patient is diagnosed with a condition which is covered under Medical Second Opinion, Mediguide covers any Medical Condition.
- The member calls MediGuide's local service center (111-11-2273) to establish eligibility and initiates the Medical Second Opinion service.
- Patient must sign a form consenting to the release of their medical records and details. The doctor will then prepare the relevant patient medical records for MediGuide.
- MediGuide will identify 3 medical centers available to provide the review and gives the names to the patient and doctor.
- Patient and doctor choose the medical center they wish to use for the Medical Second Opinion from the list of 3 provided. Within 10 business days of receipt of medical records, both the patient and/or doctor will receive a written review from the selected medical center of the original diagnosis and a proposed treatment plan, subject to data protection

Conditions for Medical Second Opinion (MSO):

Mediguide is able to review any medical Diagnosis with a MSO with the exception of the following circumstances:

1. No diagnosis
2. No evaluation by a treating physician For > 1 years
3. Condition is acute or life threatening (requires immediate medical intervention)
4. An in-person evaluation is required (e.g. mental illness)

CLAIMS

Where the indemnity is on a reimbursement basis, a fully completed Claim Form together with required supporting information/documents such as discharge summary, prescriptions, payment receipts, itemized hospital bill, any other relevant supporting document where applicable etc. must be submitted to the Company, in original, within 30 days of the date of commencement of the event which gave rise to the claim. Photo copies are not acceptable.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event later than 90 days from date of such loss. No action in law or equity shall be brought to recover under the Policy until after the expiration of 90 days from the date Proof of loss has been furnished in accordance with Policy conditions. No such action shall be brought after the expiration of one year from the time written proof of loss is required to be furnished.

EXAMINATIONS

The Company shall have the right and opportunity through its medical representative to examine the person of the Insured when and as often as it may reasonably require during the pendency of a claim hereunder. The expenses of such examinations shall be borne by the Company.

BENEFITS & THEIR PAYMENT

The benefits payable by the Company in respect of the expenses incurred for the treatment provided to an Insured during the policy period shall be limited to:

i. Reasonable and Customary charges for the treatment &
ii. The Insureds" benefit limit stated on the Schedule of Benefits.

The benefits, payable under the terms of this policy, which have not been paid directly by the Company to the Panel Hospital, shall be paid to the Policyholder.

CURRENCY OF PAYMENT

All payments under this policy shall be made in the legal currency of Pakistan.

NON-DUPLICATION OF BENEFITS

If the Insured is entitled to indemnity from any other source in respect of the same Disability, including but not restricted to indemnity from another group or individual health insurance policy, then the Company will only pay reimbursement on a proportionate basis. The Company has full rights of subrogation and may undertake legal proceedings in the Covered Person's name, but at the Company's expense, to recover for the Company's benefit from the other insurance company, any payment made by the Company.

EXCLUSIONS: See section titled 'Exclusions'.

The exclusions in this section are in addition to any other exclusion that may be contained in a specific benefit section.

This policy does not insure and no benefits shall be paid for expenses resulting from:

1. Benefits will not be available for Any Pre-existing condition, beyond the extent mentioned in the schedule of benefits.
2. Any Treatment incurred within 30 days of the commencement of the Policy Period except those incurred as a result of Accidental Bodily Injury. This does not apply to any subsequent and continuous renewal of the policy.
3. Any Treatment not recommended by a legally licensed Physician or which is not medically necessary.
4. Mental illnesses, psychiatric disorders and any sickness or condition arising from, and including drug abuse, alcoholism or an Insured's criminal act.
5. Routine physical check-ups, rest cures, services including immunization.
6. Supply or fitting of eye glasses, contact lenses, hearing aids, wheelchairs, dentures, cruches and medical appliances not required surgically.
7. Any In-Patient dental Treatment, X- rays, extractions or fillings unless necessitated due to accidental injury occurring while the insured was covered.
8. Cost of limbs any other organ(prostheses).
9. Treatment of any refractive errors of the eyes including cost of procedures such as 'Radial Keratotomy ' and ' Excimer Laser'.
10. Weight reduction/enhancement programs.
11. Any cosmetic Treatment or plastic surgery, unless necessitated due to accidental injuries occurring while the Insured was covered under the scheme.
12. Injury or illness, due to war or due to active participation in riots or civil war or civil commotion.
13. Self-inflicted injuries while sane or insane, including attempted suicide.
14. Engaging in air travel, except when travelling in a licensed aircraft being operated by a licensed airline according to published schedules.
15. Any kind of inpatient treatment which could generallybe done on an Outpatient basis or any Hospital Confinement primarily for diagnostic purposes, unless specifically authorized by the Company in writing.
16. Treatment or surgical operation for congenital defects or deformities beyond the extent mentioned in the schedule of benefits
17. Pregnancy and complications thereof, childbirth (including surgical delivery), miscarriage, abortion and/or any related prenatal or postnatal care, circumcision.

18. Treatment of infertility, impotency, sterilization & contraception including any complication relating hereto.
19. Treatment for injuries sustained as a result of participation by the Insured in any dangerous sport, pastime or competition, including but not restricted to riding, driving in any race or competition and engaging in professional sport.
20. Any increase in the expenses incurred for the treatment on account of the Insured being admitted to a more expensive room than allowed by his daily room rent limit.
21. Treatment for injuries sustained as a result of participation by the Insured in an act which is illegal according to the laws of Pakistan.
22. Any Outpatient Treatment
23. Any charges in respect of the donor for any organ transplant claim.
24. Any experimental and or unproven Treatment.
25. Sexually transmitted diseases or any expense in connection with Acquired Immune Deficiency Syndrome (AIDS) or HIV.
26. Any Non allopathic expenses.
27. Treatment from Non-Panel Hospital.
28. Switching of Plans not allowed during the policy may be changed at the time of renewal.

SECTION III

DEFINITIONS

For the purpose of this policy the following words shall have the meaning as under, wherever they appear in the policy document:

'Actively At Work' means that a Policyholder will be considered to be Actively at work on any day if he is then performing or is capable of performing in the customary manner all of the regular duties of his employment on the last scheduled working day. A person will be considered to have satisfied the Actively at work provisions on any day if he is then able to perform all the normal activities of a typical person of the same age and sex, and is confined neither at home nor in a hospital or any other medical facility.

'Company' means Jubilee General Insurance Company Ltd.

'Covered Individual' subject to the payment of the required premium, includes the Policyholder, as defined herein, provided such coverage has been applied for and has been approved by the Company and is in force under the provisions of this policy.

Credit Card/Online Payment Coverage purchased by credit card is subject to validation and acceptance by the credit card company and the Card issuing bank.

Confidential Information

All information provided shall be kept for Company's use and will not be shared with third parties, vendors &/or contractors. Please note that Credit card information is also not Stored by the Company and that Company shall not be liable for any fraudulent usage of your Card. Company maintains secured technology processes to safeguard the information provided.

'Disability' means a Sickness or Injury necessitating medical treatment by a licensed physician.

'Eligible Expenses' means expenses incurred on treatment by a covered person that are payable by the company and which are:

a) Reasonable and Customary
b) Medically Necessary
c) Within policy coverage and limits; and
d) Not excluded under any of the terms and conditions of this policy.

'Emergency' means a sudden illness or injury which raises a professional concern that there may be a significant medical problem jeopardizing the Insured's life and which necessitates Treatment which must not be delayed and which require confinement to the emergency facility of a Hospital.

'Health Card' means the identification card issued to the Policyholder.

'Hospital' means an institution that:

a) Is properly licensed to provide medical care in accordance with the laws of Pakistan;
b) Is primarily engaged in providing diagnostic, medical and surgical Facilities;
c) Has 24 hours-a-day nursing service by registered graduate nurses under the permanent supervision of the Physician in charge;
d) Maintains in-patient facilities; and
e) Maintains a daily medical record for each of its patients, which is accessible to the Company.

'Hospital Confinement' means that a covered person is registered as a bed-patient in a hospital and incurs a daily room charge.

'Insured' or 'Covered Person', means either the Policyholder, or the person selected for cover as per the Eligibility Clause of the policy and mentioned on the schedule of benefits. Provided such coverage has been applied for and has been approved by the Company and is in force under the provisions of this policy.

'Injury' means any bodily injury caused in an accident by violent, external and visible means, and which shall have occurred solely by and independently of any other cause.

'Limit Per Person' means the maximum amount payable to a Person during the Policy Year

'Maximum Eligibility Age' means the maximum age to which an Insured can be covered as under:

Policyholder	45-70 years, Once enrolled, cover can continue till the 75th birthday.

Medically Necessary" means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

- is required for the medical management of the illness or injury suffered by the insured;

- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity; and not just for the convenience of the Insured.

- must have been prescribed by a medical practitioner,

- must conform to the professional standards widely acceptedin international medical practice or by the medical community in Pakistan

'Medical 2nd Opinion(MSO)' means International Medical 2nd Opinion from Mediguide International, a world leading Medical Assistance provider.

'Non-Panel Hospital' means any hospital, day care center or other provider that is not part of the network.

'Online Doctor Consultation' means Online Audio/Video doctor consultation through our partner.

'Outpatient' means treatment is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

'Panel Hospital' means a hospital approved and identified by the Company to provide Treatment to covered Persons, and which is included in the List of Panel Hospitals attached to this policy. The list may be amended from time to time by mutual agreement between the Policyholder and the Company.

'Parents' shall mean parents/parents in law of the Policyholder who are the resident of Pakistan.

'Physician' means an individual who is legally licensed in Pakistan, under a degree recognized by the Government of Pakistan, and who:

a) is someone other than the Covered Person;
b) is not related by blood or marriage to the Covered Person;
c) is qualified to treat the Disability for which the claim is being made.

'Policy' means this agreement, its schedule (and any endorsements attaching to or forming part thereof) and the policy document, claims procedures, along with the application and any claim form.

'Policy Effective Date' means the date and time from which this policy takes effect, and as shown on the Schedule of Benefits

'Policy Expiry Date' means the date and time when cover ceases.

'Policy Year' means a twelve-month period starting from the Policy Effective Date, or a Renewal Date, s h o w n on t h e S c h e d u l e of Benefits.

'Policyholder' means a person so named in the Schedule of Benefits.

'Pre-existing Conditions' means any illness or injury or related condition for which treatment, or medication, or advice, or diagnosis was sought or received prior to the commencement of this Policy for the Insured concerned OR which was known or reasonably should have been known to exist prior to the commencement of this Policy for the Insured or in respect of which the need for treatment was foreseeable at inception of this Policy whether or not treatment or medication or advice or diagnosis had been sought or received.

'Reasonable and Customary Charges' meanscharges for Medically Necessary Treatment of a standard customarily provided for the medical condition concerned. Such charges should not exceed the general level of charges being made by other Hospitals or Physicians when giving like or comparable treatment, services or supplies to individuals of the same sex and of comparable age for a similar disease or injury. Regardless of whether medical treatment is obtained within or outside Pakistan Reasonable and Customary charges shall mean, what is Reasonable and Customary in the area of residence within Pakistan where the insured normally lives.

'Renewal Date' means any subsequent anniversary of the Policy Effective Date.

'Sickness' means a disease or pathological condition leading to the impairment of normal physiological function which manifest s itself during the Policy Period and requires medical Treatment.

'Surgical Operation' means only the following:

1. A cutting operation
2. Suturing a wound
3. Treatment of a fracture
4. Reduction of a dislocation
5. Radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for the removal of tumors
6. Electrocautherization
7. Therapeutic endoscopic procedures.

'Treatment' means a surgical procedure or medical intervention to cure a Disability.

The masculine pronoun shall be construed, as the feminine and the singular as plural if the context so requires.

SECTION IV

OUT-PATIENT EXPENSE BENEFIT

Subject to the expense limits Out-Patient Expense Benefits as stated in the Schedule Of Benefits, and other terms and conditions of the policy, the Company shall pay for Reasonable and Customary charges for all Medically Necessary Out Patient Treatment, provided on the advice of a Physician to the Insured, occurring while the Insured is covered under the policy.

The following benefits are payable:

- Consultations with Physicians
- Prescribed medicines
- Laboratory and X-ray tests and examinations
- ECG and EEG examinations & other diagnostic tests
- Dental treatments, except orthodontics, polishing and scalings
- Eye examinations
- Pre-natal and post-natal treatments, tests and supplies, while not confined in a hospital

Exclusions

Non-Medical items

CONDITIONS

In addition to all the conditions stated in the above-mentioned Policy, the following conditions are also applicable to this Rider.

- All Pre existing are covered under this rider.
- With terminating of cover under basic hospitalization policy, cover under this rider will automatically cease.

CLAIMS SUBMISSION & REIMBURSEMENT PROCESS

Submit all OPD claim receipts/invoices to: Parents.OPDClaims@jubileegeneral.com.pk

b. The Company will reimburse OPD claims as per the plan's OPD limit, following due verification, within three (3) business days.

c. Reimbursement will be made via Pay Order, Cheque, or IBFT, based on the Participant's preference.

d. For any assistance regarding OPD claims, please contact our helpline at 0800-03786.