International Healthcare Plans for the UAE (Direct Settlement)

Employee Benefit Guide

Valid from 1st November 2016

orient
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Allianz Worldwide Care Designed Products

Your healthcare cover

This Benefit Guide sets out the standard benefits and rules of your healthcare cover. Please read this guide in conjunction with your Table of Benefits, Access Card and Insurance Certificate (available on request).

Your Access Card details the geographical area of cover that your company has chosen for you and your dependents (if applicable) as well as the start date and renewal date of your cover. Please note that we will send you a new Access Card if we need to record any changes requested by your company or which we are entitled to make, or if, with your company's approval and our acceptance, you request a change such as adding a dependent.

Your Table of Benefits outlines the plan(s) selected by your company and the associated benefits available to you. In addition, it specifies any benefits/treatments which require submission of a Pre-authorization Form and confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply. Your Table of Benefits will be issued in US Dollars.

For full details of your company's insurance contract, please contact your company's Group Scheme Manager. Please note that the terms and conditions of your membership may be changed from time to time by agreement between your company and us.

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Your cover

Overview

The overall purpose of this policy is to provide cover for reasonable and customary expenses incurred through the medically necessary treatment of medical conditions, illnesses and injuries as covered within the terms of the policy.

Your Table of Benefits specifies the plan(s) selected by your company and the associated benefits available to you. This could be one of our Core Plans, which might have been chosen in combination with one of our Out-patient, Dental or Repatriation Plans, or your plan may have been designed specifically for your company. Cover is subject to our policy definitions, exclusions and benefit limits.

You will find further details about our benefits in the "Definitions" section of this guide, however if you have any queries regarding what you are covered for, please do not hesitate to call us.

We would like to bring your attention to the following important points:

Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits. The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan. Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. "65% refund, up to US$7,100". Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

Benefit limits for "Routine maternity" and "Complications of pregnancy and childbirth" are payable on either a "per pregnancy" or "per Insurance Year" basis (this will be confirmed in your Table of Benefits). If your benefit is payable on a "per pregnancy" basis and a pregnancy spans two Insurance Years, please note that if a change is applied to the benefit limit at policy renewal, the following will apply:

- All eligible expenses incurred in the first year will be subject to the benefit limit that applies in year one.
- All eligible expenses incurred in the second year will be subject to the updated benefit limit that applies in year two, less the total benefit amount reimbursed in year one.
- In the event that the benefit limit decreases in year two and this updated amount has been reached or exceeded by eligible costs incurred in year one, no additional benefit amount will be payable.

For multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to US$42,500 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

Medical necessity and customary charges

This policy provides cover for medical treatment, related costs, services and/or supplies that we determine to be medically necessary and appropriate to treat a patient's condition, illness or injury. Plus we will only reimburse medical providers where their charges are reasonable and customary in accordance with standard and generally accepted medical procedures. If a claim is deemed by us to be inappropriate, we reserve the right to reduce the amount payable by us.

If you are uncertain whether your planned medical treatment is covered under your plan, please contact our Helpline.

Pre-existing conditions

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependents could reasonably have been assumed to have known, will be deemed to be pre-existing.

Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered within the limits of your plan.

Geographical area of cover

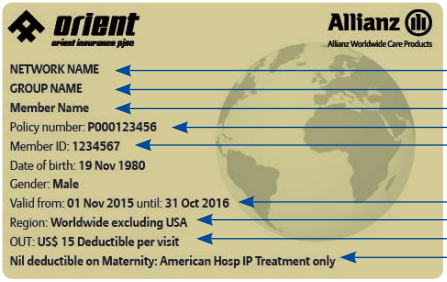
Please refer to your Access Card to confirm your geographical area of cover (unless you have been advised otherwise).

Your Access Card

A personalized Access Card is issued to every insured person, which contains essential contact numbers. This means that you and your family are only a phone call away from help. We suggest that you keep this card with you at all times. Acceptance and use of the Access Card automatically implies acceptance of all the terms, conditions, limitations and exclusions of this policy.

The Access Card aims to establish your identity and allows you to access the network of clinics, hospitals and pharmacies assigned to your healthcare plan. It is not transferable and should be returned or destroyed when membership ceases. The validity of the card is subject to continuity of membership.

Please note that we will send you a new Access Card if we need to record any changes requested by your company or which we are entitled to make, or if, with your company's approval and our acceptance, you request a change such as adding a dependent. Your new Access Card(s) will replace any earlier version(s) you possess from the start date shown on the new card(s). Earlier versions should be destroyed or returned to us.



Definitions

The following definitions apply to the benefits included in our range of Healthcare Plans and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. If any unique benefits apply to your plan(s), the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever the following words/phrases appear in your policy documents, they will always be defined as follows:

1.1 **Accident** is a sudden, unexpected event which causes injury and is due to a cause external to the insured person. The cause and symptoms must be medically and objectively definable, allow for a diagnosis and require therapy.

1.2 **Accidental death benefit** refers to an amount shown in the Table of Benefits which shall become payable if an insured person (aged 18 to 70) passes away during the period of insurance as a result of an accident (including industrial injury).

1.3 **Accommodation costs for one parent staying in hospital with an insured child** refers to the hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of a three star hotel daily room rate towards any hotel costs incurred. We will not, however, cover sundry expenses including, but not limited to, meals, telephone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

1.4 **Accommodation costs for one person accompanying an insured person in cases of medical necessity** refer to the accommodation costs of an accompanying person staying in the same hospital room as an insured person, in the event that they require hospitalization. Accommodation costs will be covered for the duration of the insured person's admission for eligible treatment while they are in a critical condition (i.e. where the condition is potentially life threatening), up to the applicable benefit limit. Pre-authorization is required.

1.5 **Acute** refers to sudden onset.

1.6 **Chronic condition** is defined as a sickness, illness, disease or injury which has one or more of the following characteristics:

- Is recurrent in nature.
- Is without a known, generally recognized cure.
- Is not generally deemed to respond well to treatment.
- Requires palliative treatment.
- Requires prolonged supervision or monitoring.
- Leads to permanent disability.

Please refer to the "Notes" section of your Table of Benefits to confirm whether chronic conditions are covered.

1.7 **Company** is your employer whose name is mentioned in the Company Agreement.

1.8 **Company Agreement** is the agreement we have with your employer, which allows you and your dependents to be insured with us. This agreement sets out who can be covered, when cover begins, how it is renewed and how premiums are paid.

1.9 **Complementary treatment** refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. Such medicine only includes chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practiced by approved therapists.

1.10 **Complications of childbirth** refer only to the following conditions that arise during childbirth and that require a recognized obstetric procedure: post-partum hemorrhage and retained placental membrane. Where the insured's plan also includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.

1.11 **Complications of pregnancy** relate to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.

1.12 **Co-payment** is the percentage of the costs which the insured person must pay. These apply per person, per Insurance Year, unless indicated otherwise in the Table of Benefits. Some plans may include a maximum co-payment per insured person, per Insurance Year, and if so, the amount will be capped at the amount stated in your Table of Benefits. Co-payments may apply individually to the Core, Out-patient, Dental or Repatriation Plans, or to a combination of these plans.

1.13 **Day-care treatment** is planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

1.14 **Deductible** is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum. Where applied, deductibles are payable per person per Insurance Year, unless indicated otherwise in the Table of Benefits, and apply to the Out-patient Plan, in respect of any out-patient treatment (i.e. treatment that does not require admission to hospital). Please refer to your Access Card to determine the amount of deductible (if any), that applies to your out-patient benefits.

1.15 **Dental prescription drugs** are those prescribed by a dentist for the treatment of a dental inflammation or infection. The prescription drugs must be proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. This does not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

1.16 **Dental prostheses** include crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

1.17 **Dental surgery** includes the surgical extraction of teeth, as well as other tooth related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures necessary to establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover any surgical treatment that is related to dental implants.

1.18 **Dental treatment** includes an annual check up, simple fillings related to cavities or decay, root canal treatment and dental prescription drugs.

1.19 **Dependent** is your spouse or partner (including same sex partner) and/or unmarried children (including any step, fostered or adopted children) financially dependent on the principal member up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also declared to us by your company as one of your dependents.

1.20 **Diagnostic tests** are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

1.21 **Dietician fees** relate to charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practice in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.

1.22 **Direct family history** exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

1.23 **Emergency** constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

1.24 **Emergency in-patient dental treatment** refers to acute emergency dental treatment due to a serious accident requiring hospitalization. The treatment must be received within 24 hours of the emergency event. Please note that cover under this benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

1.25 **Emergency out-patient dental treatment** is treatment received in a dental surgery/hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth, including pulpotomy or pulpectomy and the subsequent temporary fillings limited to three fillings per Insurance Year. The treatment must be received within 24 hours of the emergency event. This does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. If your company also selected a Dental Plan for you, you will be covered under the terms of this plan for dental treatment in excess of the (Core Plan) emergency out-patient dental treatment benefit limit.

1.26 **Emergency out-patient treatment** is treatment received in a casualty ward/emergency room within 24 hours of an accident or sudden illness, where the insured does not, out of medical necessity, occupy a hospital bed. If your company also selected an Out-patient Plan for you, you are covered under the terms of this plan for out-patient treatment in excess of the (Core Plan) emergency out-patient treatment benefit limit.

1.27 **Emergency treatment outside area of cover** is treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided up to a maximum period of six weeks per trip within the maximum benefit amount and includes treatment required in the event of an accident, or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a physician, medical practitioner or specialist must commence within 24 hours of the emergency event. Cover is not provided for any curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover, nor does it cover charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. You should advise your company's Group Scheme Manager if you are moving outside your area of cover for more than six weeks.

1.28 **Expenses for one person accompanying an evacuated/repatriated person** refer to the cost of one person traveling with the evacuated/repatriated person. If this cannot take place in the same transportation vehicle, transport at economy rates will be paid for. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the accompanying person to return to the country from where the evacuation/repatriation originated. Cover does not extend to hotel accommodation or other related expenses.

1.29 **Family history** exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

1.30 **Group Scheme Manager** is the designated representative of the company acting as the key point of contact between the company and us for matters relating to the administration of the plan such as enrolment, premium collection and renewal.

1.31 **Health and wellbeing checks including screening for the early detection of illness or disease** are health checks, tests and examinations, performed at an appropriate age interval, that are undertaken without any clinical symptoms being present. Checks are limited to:

- Physical examination.
- Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test).
- Cardiovascular examination (physical examination, electrocardiogram, blood pressure).
- Neurological examination (physical examination).
- Cancer screening:
  - Annual pap smear (where included in your Table of Benefits).
  - Mammogram (every two years for women aged 45+, or earlier where a family history exists).

  - Prostate screening (yearly for men aged 50+, or earlier where a family history exists).
  - Colonoscopy (every five years for members aged 50+, or 40+ where a family history exists).
  - Annual fecal occult blood test.
- Bone densitometry (every five years for women aged 50+).
- Well child test (for children up to the age of six years, up to a maximum of 15 visits per lifetime).
- BRCA1 and BRCA2 genetic test (where a direct family history exists and where included in your Table of Benefits).

1.32 **Home country** is a country for which the insured person holds a current passport or is their principal country of residence.

1.33 **Hospital** is any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centers and health resorts.

1.34 **Hospital accommodation** refers to standard private or semi-private accommodation as indicated in the Table of Benefits. Deluxe, executive rooms and suites are not covered. Please note that the hospital accommodation benefit only applies where no other benefit included in your plan covers the required in-patient treatment. In this case, hospital accommodation costs will be covered under the more specific in-patient benefit, up to the benefit limit stated. Psychiatry and psychotherapy, organ transplant, oncology, routine maternity, palliative care and long term care are examples of in-patient benefits which include cover for hospital accommodation costs, up to the benefit limit stated, where included in your plan.

1.35 **Infertility treatment** refers to treatment for the insured person including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. If your Table of Benefits does not have a specific benefit for infertility treatment, cover is limited to non-invasive investigations into the cause of infertility, within the limits of your Out-patient Plan (if your company selected one). If, however, there is a specific benefit for infertility treatment, the cost for infertility treatment will be covered for the insured member who receives the treatment, up to the limit indicated in the Table of Benefits. Any costs exceeding the benefit limit cannot be claimed under the cover of the spouse/partner (if included in the policy). In the case of InVitro Fertilization (IVF), cover is limited to the amount specified in the Table of Benefits. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to US$42,500 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

1.36 **In-patient cash benefit** is payable when treatment and accommodation for a medical condition, that would otherwise be covered under the insured's plan, is provided in a hospital where no charges are billed. Cover is limited to the amount specified in the Table of Benefits and is payable upon discharge from hospital.

1.37 **In-patient treatment** refers to treatment received in a hospital where an overnight stay is medically necessary.

1.38 **Insurance Certificate** is a document outlining the details of your cover and is issued by us. It confirms that an insurance relationship exists between your company and us.

1.39 **Insurance Year** applies from the effective date of the insurance, as indicated on the Access Card and ends at the expiry date of the Company Agreement. The following Insurance Year coincides with the year defined in the Company Agreement.

1.40 **Insured person** is you and your dependents as declared to us by your company.

1.41 **Local ambulance** is ambulance transport required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

1.42 **Long term care** refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long term care can be provided at home, in the community, in a hospital or in a nursing home.

1.43 **Medical evacuation** applies where the necessary treatment for which the insured person is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the insured person to the nearest appropriate medical center (which may or may not be located in the insured person's home country) by ambulance, helicopter or airplane. The medical evacuation, which should be requested by your physician, will be carried out in the most economical way having regard to the medical condition. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the evacuated member to return to his/her principal country of residence.

If medical necessity prevents the insured person from undertaking the evacuation or transportation following discharge from an **in-patient episode of care**, we will cover the reasonable cost of hotel accommodation up to a maximum of seven days, comprising of a private room with en-suite facilities. We do not cover costs for hotel suites, four or five star hotel accommodation or hotel accommodation for an accompanying person.

Where an insured person has been evacuated to the nearest appropriate medical center for **ongoing treatment**, we will agree to cover the reasonable cost of hotel accommodation comprising of a private room with en-suite facilities. The cost of such accommodation must be more economical than successive transportation costs to/from the nearest appropriate medical center and the principal country of residence. Hotel accommodation for an accompanying person is not covered.

Where adequately screened blood is not available locally, we will, where appropriate, endeavor to locate and transport screened blood and sterile transfusion equipment, where this is advised by the treating physician. We will also endeavor to do this when our medical experts so advise. Neither we, nor our agents accept any liability in the event that such endeavors are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

Members must contact us at the first indication that an evacuation is required. From this point onwards we will organize and coordinate all stages of the evacuation until the insured person is safely received into care at their destination. In the event that evacuation services are not organized by us, we reserve the right to decline all costs incurred.

1.44 **Medical necessity** refers to medical treatment, services or supplies that are determined to be medically necessary and appropriate. They must be:

(a) Essential to identify or treat a patient's condition, illness or injury.
(b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.
(c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time.
(d) Required for reasons other than the comfort or convenience of the patient or his/her physician.
(e) Proven and demonstrated to have medical value.
(f) Considered to be the most appropriate type and level of service or supply.
(g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
(h) Provided only for an appropriate duration of time.

In this definition, the term "appropriate" means taking patient safety and cost effectiveness into consideration. When specifically applied to in-patient treatment, medically necessary also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided on an out-patient basis.

1.45 **Medical practitioner** is a physician who is licensed to practice medicine under the law of the country in which treatment is given and where he/she is practicing within the limits of his/her license.

1.46 **Medical practitioner fees** refer to non-surgical treatment performed or administered by a medical practitioner.

1.47 **Medical repatriation** is an optional level of cover and where provided will be shown in the Table of Benefits. This benefit means that if the necessary treatment for which you are covered is not available locally you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical center. This only applies when your home country is located within your geographical area of cover. Following completion

of treatment, we will also cover the cost of the return trip, at economy rates, to your principal country of residence. The return journey must be made within one month after treatment has been completed.

Members must contact us at the first indication that repatriation is required. From this point onwards we will organize and coordinate all stages of the repatriation until the insured person is safely received into care at their destination. In the event that repatriation services are not organized by us, we reserve the right to decline all costs incurred.

1.48 **Midwife fees** refers to fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has fulfilled the necessary training and passed the necessary state examinations.

1.49 **Newborn care** includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out up to a maximum of 30 days following birth. BCG and Hepatitis B vaccinations plus neo-natal screening (limited to Phenylketonuria (PKU), congenital hypothyroidism, sickle cell and congenital adrenal hyperplasia tests) are also covered for this period. Pre-authorization is required. Further preventive diagnostic procedures such as routine swabs, blood typing and hearing tests are not covered. Any medically necessary follow-up investigations, treatments and vaccinations will be covered under the newborn's own policy.

1.50 **Non-prescribed physiotherapy** refers to treatment by a registered physiotherapist where referral by a medical practitioner has not been obtained prior to undergoing treatment. Where this benefit applies, cover is limited to the number of sessions indicated in your Table of Benefits. Additional sessions required over and above this limit must be prescribed in order for cover to continue; these sessions will be subject to the prescribed physiotherapy benefit limit. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

1.51 **Nursing at home or in a convalescent home** refers to nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will only pay the benefit listed in the Table of Benefits where the treating doctor decides (and our Medical Director agrees) that it is medically necessary for the insured person to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure centers and health resorts or in relation to palliative care or long term care (see definitions 1.62 and 1.42).

1.52 **Obesity** is diagnosed when a person has a Body Mass Index (BMI) of over 30.

1.53 **Occupational therapy** refers to treatment that addresses the individual's development of fine and gross motor skills, sensory integration, coordination, balance and other skills such as dressing, eating, grooming, etc. in order to aid daily living and improve interactions with the physical and social world. A progress report is required after 20 sessions.

1.54 **Oculomotor therapy** is a specific type of occupational therapy that aims to synchronize eye movement in cases where there is a lack of coordination between the muscles of the eye.

1.55 **Oncology** refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis. We will also cover the cost of a wig in the event of hair loss as a result of cancer treatment.

1.56 **Oral and maxillofacial surgical procedures** refer to surgical treatment performed by an oral and maxillofacial surgeon in a hospital as a treatment for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours. Please note that surgical removal of impacted teeth, surgical removal of cysts and orthognathic surgeries for the correction of malocclusion, even if performed by an oral and maxillofacial surgeon, are not covered unless a Dental Plan has also been selected.

1.57 **Organ transplant** is the surgical procedure in performing the following organ and/or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/ skeletal and cornea transplants. Expenses incurred in the acquisition of organs are not reimbursable.

1.58 **Orthodontics** is the use of devices to correct malocclusion and restore the teeth to proper alignment and function. We only cover orthodontic treatment where the standard metallic braces and/or standard removable appliances are used. Cosmetic appliances such as lingual braces and invisible aligners are covered up to the cost of metallic braces, subject to the "Orthodontic treatment and dental prostheses" benefit limit.

1.59 **Orthomolecular treatment** refers to treatment which aims to restore the optimum ecological environment for the body's cells by correcting deficiencies on the molecular level based on individual biochemistry. It uses natural substances such as vitamins, minerals, enzymes, hormones, etc.

1.60 **Out-patient surgery** is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require the patient to stay overnight out of medical necessity.

1.61 **Out-patient treatment** refers to treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require the patient to be admitted to hospital.

1.62 **Palliative care** refers to ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life. It includes in-patient, day-care or out-patient treatment following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition. We will also pay for physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs.

1.63 **Periodontics** refers to dental treatment related to gum disease.

1.64 **Post-natal care** refers to the routine post-partum medical care received by the mother, up to six weeks after delivery.

1.65 **Pre-existing conditions** are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependents could reasonably have been assumed to have known, will be deemed to be pre-existing. Conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

1.66 **Pregnancy** refers to the period of time, from the date of first diagnosis, until delivery.

1.67 **Pre-natal care** includes common screening and follow up tests as required during a pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis.

1.68 **Prescribed drugs** refer to products prescribed by a physician for the treatment of a confirmed diagnosis or medical condition, or to compensate vital bodily substances including, but not limited to, insulin, hypodermic needles or syringes. The prescribed drugs must be clinically proven to be effective for the condition and recognized by the pharmaceutical regulator in a given country. Prescribed drugs do not legally have to be prescribed by a physician in order to be purchased in the country where the insured person is located; however, a prescription must be obtained for these costs to be considered eligible.

1.69 **Prescribed glasses and contact lenses including eye examination** refers to cover for an eye examination carried out by an optometrist or ophthalmologist (one per Insurance Year) and for lenses or glasses to correct vision.

1.70 **Prescribed medical aids** refer to any device which is prescribed and medically necessary to enable the insured person to function to a capacity consistent with everyday living where reasonably possible. This includes:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.
- Hearing and speaking aids such as an electronic larynx.
- Medically graduated compression stockings.
- Long term wound aids such as dressings and stoma supplies.

Costs for medical aids that form part of palliative care or long term care (see definitions 1.62 and 1.42) are not covered.

1.71 **Prescribed physiotherapy** refers to treatment by a registered physiotherapist following referral by a medical practitioner. Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a new progress report must be submitted to us after every set of 12 sessions, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

1.72 **Prescription drugs** refers to products, including, but not limited to, insulin, hypodermic needles or syringes, which require a prescription for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective for the condition and recognized by the pharmaceutical regulator in a given country.

1.73 **Preventive services** are limited to checks and investigations related to diabetes (such as glucose or blood tests) and annual Pap (Papanicolaou) smear tests. Diabetes tests are performed every three years for members aged 30+, or yearly for members aged 18+ if there is a high risk of diabetes developing.

1.74 **Preventive treatment** refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment. An example of such treatment is the removal of a pre-cancerous growth.

1.75 **Principal country of residence** is the country where you and your dependents (if applicable) live for more than six months of the year.

1.76 **Psychiatry and psychotherapy** is the treatment of mental disorders carried out by a psychiatrist or clinical psychologist. The condition must be clinically significant and not related to bereavement, relationship or academic problems, acculturation difficulties or work pressure. All day-care or in-patient admissions must include prescription medication related to the condition. Psychotherapy treatment (on an in-patient or out-patient basis) is only covered where you or your dependents are initially diagnosed by a psychiatrist and referred to a clinical psychologist for further treatment. In addition, out-patient psychotherapy treatment (where covered) is initially restricted to 10 sessions per condition, after which treatment must be reviewed by the referring psychiatrist. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment.

1.77 **Rehabilitation** is treatment in the form of a combination of therapies such as physical, occupational and speech therapy and is aimed at the restoration of a normal form and/or function after an acute illness, injury or surgery. The rehabilitation benefit is only payable for treatment that starts within 14 days of discharge after the acute medical and/or surgical treatment ceases and where it takes place in a licensed rehabilitation facility.

1.78 **Repatriation of mortal remains** is the transportation of the insured person's mortal remains from the principal country of residence to the country of burial. Covered expenses include, but are not limited to, expenses for embalming, a container legally appropriate for transportation, shipping costs and the necessary government authorizations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered unless this is listed as a specific benefit in your Table of Benefits.

1.79 **Routine maternity** refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labor only) as well as newborn care. Costs related to complications of pregnancy and childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in

the same hospital, subject to any benefit limit in place. If the home delivery benefit is included in your plan, a lump sum up to the amount specified in the Table of Benefits will be paid in the event of a home delivery.

1.80 **Specialist** is a qualified and licensed medical physician possessing the necessary additional qualifications and expertise to practice as a recognized specialist of diagnostic techniques, treatment and prevention in a particular field of medicine. This benefit does not include cover for psychiatrist or psychologist fees. Where covered, a separate benefit for psychiatry and psychotherapy will appear in the Table of Benefits.

1.81 **Specialist fees** refer to non-surgical treatment performed or administered by a specialist.

1.82 **Speech therapy** refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments, including, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

1.83 **Surgical appliances and materials** are those which are required for the surgical procedure. These include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

1.84 **Therapist** is a chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the law of the country in which treatment is being given.

1.85 **Travel costs of insured family members in the event of an evacuation/repatriation** refer to the reasonable transportation costs of all insured family members of the evacuated or repatriated person, including, but not limited to, minors who might otherwise be left unattended. If this cannot take place in the same transportation vehicle, round trip transport at economy rates will be paid for. In the event of an insured person's repatriation, the reasonable transportation costs of insured family members will only be covered if the relevant Repatriation Plan benefit forms part of your cover. Cover does not extend to hotel accommodation or other related expenses.

1.86 **Travel costs of insured family members in the event of the repatriation of mortal remains** refer to reasonable transportation costs of any insured family members who had been residing abroad with the deceased insured person, to return to the home country/chosen country of burial of the deceased. Cover does not extend to hotel accommodation or other related expenses.

1.87 **Travel costs of insured members to be with a family member who is at peril of death or who has died** refer to the reasonable transportation costs (up to the amount specified in your Table of Benefits) so that insured family members can travel to the location of a first degree relative who is at peril of death or who has died. A first degree relative is a spouse, parent, brother, sister or child, including adopted children, fostered children or step children. Claims are to be accompanied by a death certificate or doctor's certificate supporting the reason for travel as well as copies of the flight tickets, and cover will be limited to one claim per lifetime of the policy. Cover does not extend to hotel accommodation or other related expenses.

1.88 **Treatment** refers to a medical procedure needed to cure or relieve illness or injury.

1.89 **Vaccinations** refer to all basic immunizations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The cost of consultation for administering the vaccine, as well as the cost of the drug, is covered.

1.90 **Waiting period** is a period of time commencing on your policy start date (or effective date if you are a dependent), during which you are not entitled to cover for particular benefits. Your Table of Benefits will indicate which benefits are subject to waiting periods.

1.91 **We/Our/Us** is Orient Insurance PJSC.

1.92 **You/Your** refers to the eligible employee as declared to us by your company.

Exclusions

Although we cover most medically necessary treatment, expenses incurred for the following treatments, medical conditions and procedures are not covered under the policy unless confirmed otherwise in the Table of Benefits or in any written policy endorsement.

1. Any form of **treatment** or **drug therapy** which in our reasonable opinion is **experimental or unproven**, based on generally accepted medical practice.

2. Any **treatment carried out by a plastic surgeon**, whether or not for medical/psychological purposes and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident, or as a result of surgery for cancer, if the accident or surgery occurs during your membership of the scheme.

3. Care and/or treatment of **drug addiction or alcoholism** (including detoxification programs and treatments related to the cessation of smoking), instances of death, or the treatment of any condition that in our reasonable opinion is related to, or a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).

4. Care and/or treatment of **intentionally caused diseases** or **self-inflicted injuries**, including a suicide attempt.

5. **Complementary treatment**, with the exception of those treatments indicated in the Table of Benefits.

6. **Consultations performed**, as well as **any drugs or treatments prescribed, by you, your spouse, parents or children**.

7. Costs in respect of a **family therapist or counselor** for out-patient psychotherapy treatment.

8. **Dental veneers** and related procedures.

9. **Developmental delay**, unless a child has not attained developmental milestones expected for a child of that age, in cognitive or physical development. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified personnel and documented as a 12 month delay in cognitive and/or physical development.

10. Expenses for the **acquisition of an organ** including, but not limited to, donor search, typing, harvesting, transport and administration costs.

11. Expenses incurred because of **complications directly caused by an illness, injury or treatment for which cover is excluded or limited** under your plan.

12. **Genetic testing**, except where a) specific genetic tests are included within your plan; b) where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over; c) testing for genetic receptor of tumours is covered.

13. **Home visits**, unless they are necessary following the sudden onset of an acute illness, which renders the insured incapable of visiting their medical practitioner, physician or therapist.

14. **Infertility treatment** including medically assisted reproduction or any adverse consequences thereof, unless you have a specific benefit for infertility treatment, or an Out-patient Plan has been selected (whereby you are covered for non-invasive investigations into the cause of infertility within the limits of your Out-patient Plan).

15. Investigations into, and treatment of, **loss of hair** and any **hair replacement** unless the loss of hair is due to cancer treatment.

16. Investigations into, and treatment of, **obesity**.

17. Investigations into, treatment of and complications arising from **sterilization, sexual dysfunction** (unless this condition is as a result of total prostatectomy following surgery for cancer) and **contraception** including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

18. **Laser eye surgery** to change the refraction of one or both eyes, except in the event of an emergency or for the treatment of medical conditions such as glaucoma, cataract, retinal detachment and tears.

19. Medical evacuation/repatriation from a **vessel at sea** to a medical facility on land.

20. **Medical practitioner fees for the completion of a Claim Form** or other administration charges.

21. **Orthomolecular treatment** (please refer to definition 1.59).

22. In relation to underwritten groups, **pre-existing conditions** (including any pre-existing chronic conditions) which are indicated in your Table of Benefits.

23. **Pre-** and **post-natal** classes.

24. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes) and supplements including, but not limited to, special infant formula and cosmetic products, even if medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are not covered, unless a specific benefit is included within your Table of Benefits.

25. Products that can be purchased without a **doctor's prescription**, except where a specific benefit covering these costs appears in the Table of Benefits.

26. **Sex change operations** and related treatments.

27. **Speech therapy** related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

28. Stays in a **cure-center, bath center, spa, health resort** and **recovery center**, even if the stay is medically prescribed.

29. **Termination of pregnancy**, except in the event of danger to the life of the pregnant woman.

30. **Travel costs** to and from medical facilities (including parking costs) for eligible treatment, except any travel costs covered under local ambulance, medical evacuation and medical repatriation benefits.

31. Treatment directly related to **surrogacy**, whether you are acting as a surrogate, or are the intended parent.

32. Treatment for any illnesses, diseases or injuries, as well as instances of death resulting from **active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts** or **acts against any foreign hostility**, whether war has been declared or not.

33. Treatment for any medical conditions arising directly or indirectly from **chemical contamination, radioactivity** or **any nuclear material** whatsoever, including the combustion of nuclear fuel.

34. Treatment for conditions such as **conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behavior, obsessive-compulsive disorder, phobic disorders, attachment disorders, adjustment disorders, eating disorders, personality disorders** or treatments that encourage positive social-emotional relationships, such as **family therapy**, unless indicated otherwise in the Table of Benefits.

35. **Treatment in the USA** if we know or suspect that cover was purchased for the purpose of traveling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover.

36. **Treatment of sleep disorders**, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism.

37. Treatment or diagnostic procedures for **injuries arising from an engagement in professional sports**.

38. Treatment **outside the geographical area of cover**, unless for emergencies or authorized by us.

39. Treatment required as a result of **failure to seek or follow medical advice**.

40. Treatment required as a **result of medical error**.

41. **Triple/Bart's, Quadruple** or **Spina Bifida tests**, except for women aged 35 or over.

42. **Tumor marker testing**, unless you have previously been diagnosed with the specific cancer in question, in which case, cover will be provided under the Oncology benefit.

43. The following **treatments, expenses, procedures or any adverse consequences** or complications relating to them, unless otherwise indicated in your Table of Benefits:

    43.1 Accommodation costs for one person accompanying an insured person in cases of medical necessity.
    43.2 Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
    43.3 Dietician fees.
    43.4 Emergency dental treatment.
    43.5 Expenses for one person accompanying an evacuated/repatriated person.
    43.6 Health and wellbeing checks including screening for the early detection of illness or disease.

43.7 Home delivery.
43.8 Infertility treatment.
43.9 In-patient psychiatry and psychotherapy treatment.
43.10 Laser eye surgery and optical aids in the event of an emergency.
43.11 Medical repatriation.
43.12 Newborn care.
43.13 Organ transplant.
43.14 Out-patient psychiatry and psychotherapy treatment.
43.15 Out-patient treatment.
43.16 Prescribed glasses and contact lenses including eye examination.
43.17 Prescribed hearing aids in the event of an emergency.
43.18 Prescribed medical aids.
43.19 Preventive services.
43.20 Preventive treatment.
43.21 Rehabilitation treatment.
43.22 Routine maternity.
43.23 Travel costs of insured family members in the event of an evacuation/repatriation.
43.24 Travel costs of insured family members in the event of the repatriation of mortal remains.
43.25 Travel costs of insured members to be with a family member who is at peril of death or who has died.
43.26 Vaccinations.

44. The **accidental death benefit**, in circumstances where the death of an insured person has been caused either directly or indirectly by:

44.1 Active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.
44.2 Intentionally caused diseases or self-inflicted injuries, including suicide, within one year of the enrolment date of the policy.
44.3 Active participation in underground/underwater activity such as underground mining or deep sea diving.
44.4 Above water activity (such as oil platforms, oil rigs) and aerial activity, unless otherwise specified in the Company Agreement.
44.5 Chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.
44.6 Passive war risk:
- Being in a country where the British government has recommended their citizens to leave (this criteria will apply regardless of the insured person's nationality) and advised against "all travel" to that location; or

- Travelling to or staying, for a period of more than 28 days per stay, in a country or an area where the British government advises "against all but essential travel".

The passive war risk exclusion applies regardless of whether the claim arises directly or indirectly as a consequence of war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.

44.7 Being under the influence of drugs or alcohol.

44.8 Death that takes place more than 365 days after the occurrence of the accident.

44.9 Deliberate exposure to danger, except in an attempt to save human life.

44.10 Intentional inhalation of gas or intentional ingestion of poisons or legally prohibited drugs.

44.11 Flying in an aircraft, including helicopters, unless the insured person is a passenger and the pilot is legally licensed, or is a military pilot and has filed a scheduled flight plan when required by local regulations.

44.12 Active participation in extreme or professional sports including, but not limited to:

- Mountain sports such as abseiling, mountaineering and racing of any kind (other than on foot).
- Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
- Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.
- Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.
- Car and motorcycle sports such as motorcycle riding and quad biking.
- Combative sports.
- Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.
- Various other sports such as bungee jumping.

Additional terms

The following are important additional terms that apply to your policy with us:

1. Applicable law: Your membership is governed by United Arab Emirates (UAE) law. Any dispute that cannot otherwise be resolved will be dealt with by courts in the United Arab Emirates.

2. Data protection: We obtain and process personal information for the purposes of preparing quotations, underwriting policies, collecting premium, paying claims and for any other purpose which is directly related to administering policies in accordance with the insurance contract. The confidentiality of patient and member information is of paramount concern to us. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date. We will not retain your data for longer than is necessary for the purposes for which it was obtained.

3. Eligibility: Only those group members (and dependents) as described in the Company Agreement.

4. Force majeure: We shall not be liable for any failure or delay in the performance of our obligations under the terms of this policy, caused by, or resulting from, force majeure which shall include, but is not limited to: events which are unpredictable, unforeseeable or unavoidable, such as extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labor unrest, civil disturbances, sabotage, expropriation by governmental authorities and any other act or event that is outside of our reasonable control.

5. Cancellation and fraud:
   a) For groups that require medical underwriting, incorrect disclosure/non-disclosure of any material facts, by you or your dependents, which may affect our assessment of the risk, including, but not limited to material facts declared on the relevant application form, may render your cover void from the start date. Conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. If the applicant is not sure whether something is relevant, the applicant is obliged to inform us.

b) If any claim is false, fraudulent, intentionally exaggerated or if fraudulent means or devices have been used by you or your dependents or anyone acting on your or their behalf to obtain benefit under this policy, we will not pay any benefits for that claim. The amount of any claim settlement made to you before the fraudulent act or omission was discovered, will become immediately due and owing to us. We reserve the right to inform your company of any fraudulent activity.

6. Liability: Our liability to the insured person is limited to the amounts indicated in the Table of Benefits and any subsequent policy endorsement. In no event will the amount of reimbursement, whether under this policy, public medical scheme or any other insurance, exceed the amount of the invoice.

7. Making contact with dependents: In order to administer your policy in accordance with the insurance contract, there may be circumstances when we will need to request further information. If we need to make contact in relation to a dependent on a policy (e.g. where further information is required to process a claim), the policyholder, acting for and on behalf of the dependent, may be contacted by us and asked to provide the relevant information. Similarly, all information in relation to any person covered by the insurance policy, for the purposes of administering claims, may be sent directly to the policyholder.

8. Third party liability: If you or any of your dependents are eligible to claim benefits under a public scheme or any other insurance policy which pertains to a claim submitted to us, we reserve the right to decline to pay benefits. The insured person must inform us and provide all necessary information, if and when entitled to claim from a third party. The insured person and the third party may not agree to any final settlement or waive our right to recover outlays without our prior written agreement. Otherwise we are entitled to recover the amounts paid from the insured person and to cancel the policy. We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made under another policy.

General information

Adding dependents

You may apply to include any of your family members as a dependent provided that you are allowed to do so under the agreement between your company and us. Notification to add a dependent should be made through your company unless otherwise stated.

Newborn infants will be accepted for cover from birth, provided that we are notified within four weeks of the date of birth. To have a newborn added to the policy, you must ask your company to submit a request in writing, including a copy of the birth certificate, to its usual contact person for membership changes. If we are notified four weeks or more after the date of birth, newborn children will be accepted for cover from the date of that notification.

Changing country of residence

It is important that you let us know if you change your country of residence as it may impact the cover or premium, even if you remain within your current geographical region of cover. Cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate and we would recommend that you seek independent legal advice in this regard, as we may no longer be able to provide you with cover. Notification of change of residence should be made through your company unless otherwise stated.

Changing your address/email address

All correspondence will be sent to the details we have on record for you unless requested otherwise. Any change in your home, business or email address should be sent to: **middleeast.services@international-healthcare.com** as soon as possible.

Claims

In relation to medical claims, please note that:

a) All claims should be submitted no later than six months after the end of the Insurance Year. If cover is cancelled during the Insurance Year, claims should be submitted no later than six months after the date that your cover ended. Beyond this time we are not obliged to settle the claim.

b) A separate Claim Form is required for each person claiming and for each medical condition being claimed for.

c) It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement, for auditing purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

d) If the amount to be claimed is less than the deductible figure under your plan, keep collecting all out-patient receipts and Claim Forms until you reach an amount in excess of your plan deductible, then forward to us all completed Claim Forms together with supporting receipts/ invoices.

e) Please specify on the Claim Form the currency in which you wish to be paid. Unfortunately, on rare occasions, we may not be able to make a payment in the currency you requested, due to international banking regulations. In this instance we will review each case individually to identify a suitable alternative currency option. If we have to make a conversion from one currency to another, we will use the exchange rate that applies on the date on which the invoices were issued, or we will use the exchange rate that applies on the date that claims payment is made. Please note that we reserve the right to choose which currency exchange rate to apply.

f) Only costs incurred as a result of eligible treatment will be reimbursed within the limits of your policy, after taking into consideration any Pre-authorization requirements. Any deductibles or co-payments outlined in the Table of Benefits will be taken into account when calculating the amount to be reimbursed.

g) If you are required to pay a deposit in advance of any medical treatment, the cost incurred will only be reimbursed after treatment has taken place.

h) You and your dependents agree to assist us in obtaining all necessary information to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating physician. We may, at our own expense, request a medical examination by our medical representative when we deem this to be necessary. All information will be treated in strict confidence. We reserve the right to withhold benefits if you or your dependents have not honored these obligations.

Claims for accidental death

If this benefit is provided on the healthcare plan selected for you, please note that claims must be reported within 90 working days following the date of death and the following documents must be provided:

- A fully completed Accidental Death Claim Form.
- A death certificate.

- A medical report indicating the cause of death.
- A written statement outlining the date, location and circumstances of the accident.
- Official documentation proving the insured person's family status, and for the beneficiaries, proof of identity as well as proof of relationship to the insured person.

Beneficiaries are, unless otherwise specified by the insured:

- The insured person's spouse, if not legally separated.
- Failing the spouse, the insured person's surviving children including step-children, adopted or fostered children and children born less than 300 days from the date of the insured person's death; in equal shares among them.
- Failing the children, the insured person's father and mother, in equal shares between them, or to the survivor of them.
- Failing them, the insured person's estate.

If you wish to nominate a beneficiary other than those listed above, please contact our Helpline.

Please note that in the specific case of the death of the insured person and one or all of the beneficiaries in the same occurrence, the insured person shall be considered the last deceased.

Correspondence

Written correspondence between us must be sent by email or post (with the postage paid). We do not usually return original documents to you, unless you specifically request us to do so at the time of submission.

Countries where you can receive treatment

If the necessary medical treatment for which you are covered is not available locally, you can avail of treatment in any country within your geographical area of cover (please refer to your Access Card to confirm your geographical area of cover). In order to seek reimbursement for medical treatment and travel expenses incurred, pre-authorization is required prior to travel.

If the necessary medical treatment for which you are covered is available locally, but you choose to travel to another country within your geographical area of cover for treatment, we will reimburse all eligible medical costs incurred within the terms of your policy; however, we will not pay for travel expenses.

Please note that as an expatriate living abroad, you are covered for eligible costs incurred in your home country, provided that your home country is within your area of cover.

Ending membership

Your company can end your membership or that of any of your dependents by notifying us in writing. We cannot backdate the cancellation of your membership. Your membership will automatically end:

- At the end of the Insurance Year, if the agreement between us and your company is terminated.
- If your company decides to end the cover or does not renew your membership.
- If your company does not pay premiums or any other payment due under the Company Agreement with us.
- If you are an individual payer and you do not pay premiums or any other payment due under the Company Agreement with us.
- When you stop working for the company.
- Upon the death of the principal member.

We can end a person's membership and that of their dependents if there is reasonable evidence that the person concerned has misled or attempted to mislead us i.e. giving false information, withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

- Whether you (or they) can join the scheme.
- What premiums your company has to pay.
- Whether we have to pay any claim.

Making a complaint

In the case of complaints, please write to us at the address below, stating your full name, date of birth and policy number:

Orient Insurance PJSC
Allianz Worldwide Care Designed Products
02a Orient Building
Al Badia Business Park
Dubai Festival City
P.O. Box 27966
Dubai
United Arab Emirates

Other parties

No other person (except an appointed representative or the Group Scheme Manager) is allowed to make or confirm any changes to your membership on your behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is specifically agreed between your company and us.

Paying premiums

In most cases, your company is responsible for the payment of premiums to us for your membership and for the membership of any dependents also covered under the Company Agreement, together with any amount that may be due and payable in respect of membership (such as Insurance Premium Tax). Please be aware that you may be liable for payment of tax in respect of the premiums paid by your company. For details, please check with your company.

If you are responsible for paying your insurance premium

If you are responsible for paying your insurance premium, you are required to pay the premium due to us in advance, for the duration of your membership. The amount your company has agreed with us and the payment frequency you have chosen, will be shown on your Insurance Certificate. The **initial premium** or the first premium instalment is payable immediately after our acceptance of your application. Please note that if there is any difference between the agreed quotation and your invoice, you should contact us immediately. We are not responsible for payments made through third parties. **Subsequent premiums** are due on the first day of the chosen payment period.

Please note that you also have to pay us the amount of any Insurance Premium Tax (IPT), other taxes, levies or charges relating to your membership that we are required by law to pay or to collect from you. These may already be in effect when you join but they could also be introduced (or change in the future) after you join. Any such charges will be shown on your invoice.

If any changes are applied to your premiums, IPT, other taxes, levies or charges, we will write to inform you. If you do not accept any of these changes, you can choose to end your membership. We will treat the changes as having not been made if you end your membership within 30 days of the date the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Each year on the renewal date, we may change how we calculate or determine your premiums, the amount you have to pay and/or the method of payment. If so, you will be informed of these changes and they will only apply from your renewal date. Changes in payment terms can be made by you at policy renewal. Please write to us to request this at least 30 days before the renewal date.

If you are unable to pay your premium for any reason, please contact us so that we can discuss this with you, as failure to pay premiums on time may result in loss of insurance cover.

Policy expiry

Please note that upon the expiry of your policy, your right to reimbursement ends. Any eligible expenses incurred during the period of cover shall be reimbursed up to six months after the expiry date of the policy. However, any on-going or further treatment that is required after the expiry date of your policy will no longer be covered.

Pre-authorization

Your Table of Benefits will confirm which benefits available to you require pre-approval through submission of a Pre-authorization Form.

If you go to a **network hospital/clinic**, they will contact us directly for the necessary pre-authorization. A list of the hospitals and clinics in your company's chosen network is provided as part of your Membership Pack.

If you select a **hospital or clinic outside of the network, or outside the UAE**, the relevant sections of a Pre-authorization Form need to be completed by you and your physician, and then emailed or posted to us for approval prior to treatment. Please contact us **at least five working days prior to receiving treatment** so that we can ensure that there will be no delays at the time of admission. A copy of the Pre-authorization Form has been included in your Membership Pack and additional copies can be requested by calling our Helpline.

Please note that unless agreed otherwise between your company and us, if pre-authorization is not obtained, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.
- For the benefits listed in the Table of Benefits with a **1, we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **80%** of the eligible benefit.
- For the benefits listed in the Table of Benefits with a **2, we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **50%** of the eligible benefit.

Renewing membership

If your company pays for your premium, the renewal of your membership (and that of your dependents, if applicable) is subject to your company renewing your membership under the Company Agreement. If your company renews the contract with us, you (and each of your dependents, if applicable) will receive new Access Cards to use until the next renewal date (and any previous card versions should be destroyed or returned to us).

If you pay for your premium and your company renews your membership (and that of your dependents, if applicable) under the Company Agreement, your policy will be automatically renewed for the next Insurance Year, provided that we can continue to provide cover in your country of residence, all premiums due to us have been paid and the payment details we have for you are still

valid on the policy renewal date. Please update us if you get a new/replacement credit card or bank account details have changed. New Access Cards will be issued, for use until the next renewal date (and any previous card versions should be destroyed).

Treatment in the USA

For treatment in the USA, members with "Worldwide" cover should instruct their medical provider to contact **International Medical Assistance** on: **+ 353 1 629 7141** in order to verify eligibility of cover. We can then arrange direct settlement for eligible in-patient and out-patient treatment.

Please note that treatment in the USA is not covered, if we know or suspect that cover was purchased for the purpose of traveling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover. If any claims have been paid by us in relation to the treatment described above, we reserve the right to seek reimbursement from the insured person of any amounts which have already been paid in claims.

Treatment needed as a result of somebody else's fault

If you are claiming for treatment that is needed when somebody else is at fault, you must write and tell us as soon as possible; e.g. if you need treatment for an injury suffered in a road accident in which you are a victim. Please take any reasonable steps we ask of you to obtain the insurance details of the person at fault so that we can recover, from the other insurer, the cost of the treatment paid for by us. If you are able to recover the cost of any treatment for which we have paid, you must repay that amount (and any interest) to us.

When cover starts for you and your dependents

Your insurance is valid from the effective date shown on your Access Card and will continue until the group renewal date (also stated on the Access Card). Generally, this is one Insurance Year, unless agreed otherwise between your company and us or if you started your policy mid-year.
At the end of this period, your company can renew the insurance on the basis of the policy terms and conditions applicable at that time. You will be bound by those terms.

Cover for dependent's (if applicable and agreed between your company and us) will start on the effective date shown on their Access Card. Their membership may continue for as long as you remain a member of the group scheme and as long as any child dependents remain under the defined age limit. Child dependents can be covered under your policy up until the day before their 18th birthday; or up until the day before their 24th birthday if they are in full time education.

International Healthcare Plans for the UAE (Direct Settlement)

Quick start guide

You can detach this part of the Employee Benefit Guide, if you just wish to have the most commonly referenced information to hand. Your cover remains subject to our policy definitions, exclusions and benefit limits, as detailed in the full Employee Benefit Guide.

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Evacuations and repatriations

At the first indication that a medical evacuation/repatriation is required, please call our 24 hour Helpline (contact details on the back cover of this guide) and we will take care of everything. Given the urgency of an evacuation/repatriation, we would advise that you call us, however, you can also contact us by email at: **medical.services@international-healthcare.com**. When emailing, please include "*Urgent – Evacuation/ Repatriation*" in the subject line. Please contact us *before* talking to any alternative providers, even if approached by them, to avoid potentially inflated charges or unnecessary delays in the evacuation process. In the event that evacuation/repatriation services are not organized by us, we reserve the right to decline all costs incurred.

Getting treatment

Treatment within your UAE provider network

Under your insurance policy, you have access to a complete network of medical providers based in the UAE. The type of network selected for you is indicated on your **Access Card** and a **detailed list of the medical providers in your network** is issued to you as part of your Membership Pack.

1. When visiting a network medical provider, simply present your Access Card.
2. The provider will contact us directly to process the necessary paperwork.
3. We will settle the bill directly with your medical provider.

Please note that where provided under the following benefits, cover is available on a reimbursement basis only i.e. you will have to pay for eligible treatment and then complete and submit a Claim Form for:

- Health and wellbeing checks including screening for the early detection of illness or disease.
- Preventive services.
- Prescribed glasses and contact lenses including eye examination.
- All dental benefits.

If you need to purchase prescribed medication, please follow the process outlined below:

- Your treating doctor will complete the relevant online prescription form and provide you with a prescription number. You should present the prescription number to a pharmacy included in your network. The pharmacy will then submit an electronic request to us for the approval of medication costs. Once received, we will send an electronic response indicating the approval status of the request to the pharmacy and if approved you will be able to obtain your prescribed medication without making any payment (subject to the terms, conditions and benefit limits applicable to your cover).

Treatment outside your UAE provider network or outside the UAE

First, please check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm which benefits are available to you, however, you can always call our Helpline if you have any queries.

Remember, some treatments require pre-authorization

The following treatments/benefits, where covered, require pre-approval through submission of a Pre-authorization Form:

- All in-patient benefits listed (where you need to stay overnight in a hospital).
- Day-care treatment.
- Expenses for one person accompanying an evacuated/repatriated person.
- Kidney dialysis.
- Long term care.
- Medical evacuation (or repatriation).
- MRI (Magnetic Resonance Imaging), PET (Positron Emission Tomography) and CT-PET scans.
- Nursing at home or in a convalescent home.
- Occupational therapy (only out-patient treatment requires Pre-authorization).
- Oncology (only in-patient or day-care treatment requires Pre-authorization).
- Out-patient surgery.
- Palliative care.
- Rehabilitation treatment.
- Repatriation of mortal remains.
- Routine maternity, newborn care and complications of pregnancy and childbirth (only in-patient treatment requires Pre-authorization).
- Travel costs of insured family members in the event of an evacuation (or repatriation, where covered).
- Travel costs of insured family members in the event of the repatriation of mortal remains.

Use of the Pre-authorization Form helps us to assess each case and facilitate direct settlement with the hospital. Please note that we may decline your claim if Pre-authorization is not obtained. You can find full details on page 27 of this guide.

Getting in-patient treatment

If you need in-patient treatment **outside your UAE network or outside the UAE:**

1. Call our Helpline (contact details can be found at the end of this guide) in advance of your treatment and ask for a copy of the Pre-authorization Form.
2. Complete the form together with your doctor, then send it to us at least five working days prior to the start of your treatment. We will arrange for direct settlement of your bills, where possible.

If it's an emergency:

1. Get the emergency treatment you need and call us if you need any advice or support.
2. Either you, your physician, one of your dependents or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalization. Pre-authorization Form details can be taken over the phone when you call us.

Getting out-patient or dental treatment

If you receive out-patient treatment (inside or outside the UAE) from a medical provider not included in your network or if you receive any dental/eye treatment, please settle the bill directly with the medical provider. You can then seek reimbursement from us. Simply request a copy of our Claim Form by calling our Helpline and follow the steps below:

1. Get an **invoice** from the doctor/dentist/eye specialist which states your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.
2. **Complete sections 1 - 4** and **7 of the Claim Form.** Sections 5 and 6 only need to be completed by the doctor/dentist if their invoice does not state the diagnosis and nature of treatment.
3. **Send** the Claim Form and all supporting documentation, invoices and receipts to us. Details of how to submit your Claim Form and supporting documents are indicated on the Claim Form.

Without the diagnosis, we cannot process your claim promptly, as we will need to request these details from you or your doctor.

We will email or write to you to advise you of when the claim has been processed.

Please refer to the Claims section on pages 22 and 23 of this guide for additional important information about our claims process. You can find information about getting treatment in the USA on page 28.

Contact details

If you have any queries, please do not hesitate to contact us:

Helpline

Telephone: 800 6334 (calling toll-free from within the UAE)
+ 971 (0)56 681 9977 (calling from within or outside the UAE)
+ 353 1 629 7141 (International Medical Assistance **for emergency or planned hospitalization outside the UAE**)

Fax: + 971 (0)4 251 5071
Email: MEHelpline@international-healthcare.com

Address: Orient Insurance PJSC
Allianz Worldwide Care Designed Products
02a Orient Building
Al Badia Business Park
Dubai Festival City
P.O. Box 27966
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