Administered by:





WorldCare Members' Handbook

individuals and families

Everything you need to know about your international health insurance

Effective 1 April 2020

Introduction

Thank you for choosing Now Health International to administer Your international health insurance Plan.

We have designed WorldCare based on **Our** understanding of what people who buy international health insurance want and need. At the heart of this is **Our** commitment to provide clear information about how **Your Plan** works and how to use it. Please read this handbook carefully to ensure that **You** are completely satisfied that the cover provided under **Your** chosen **Plan** meets **Your** needs.

How to use this handbook

This handbook is an important document. It sets out **Your** rights and **Our** obligations to **You**. Along with the **Benefit Schedule** in section 4, it explains **Your** chosen WorldCare **Plan** and the terms of **Your** cover. Inside **You** will find details of:

- The cover You have (both Benefits and exclusions)
- Your rights and responsibilities
- How to make a claim
- How Your Plan is administered
- How to make a complaint
- Other services available to You under Your Plan

Throughout the handbook certain words and phrases appear in bold type. This indicates that they have a special medical or legal meaning – these are defined in section 1.

The **Benefits** of **Your Plan** are detailed in section 4 of this handbook. **Your Certificate of Insurance** shows the cover that is available, **Your** period and level of cover. As with any healthcare insurance contract, there are exclusions. These are **Medical Conditions** and **Treatments** that are not covered – they are listed in section 5 of this handbook.

Our service for You

When You need to use Your WorldCare Plan, here's what You can expect from Us:

- A commitment to process Your claim as quickly as possible
- A 24-hour customer service team
- Help to find suitable healthcare providers in **Your** area
- Pre-Authorisation of certain claims where possible, to reduce Your out-of-pocket expenses
- An international claims management team with the medical expertise to support You in making decisions about Your healthcare

If **You** require more details about this **Plan**, or if **You** would like to tell **Us** about any changes in **Your** personal circumstances, please contact **Us** using the details on the next page.

Contacting Us

While it is important that **You** read and understand this **Plan** members' handbook, **We** understand that there are times when it is easier to call **Us** for information. **Our** customer service team is ready to help with any queries **You** may have. For example, if **You** need **Treatment**, **You** can contact **Us** first so **We** can explain the extent of **Your** cover before **You** incur any costs.

Please note that **We** may record and/or monitor calls for quality assurance and training and as a record of **Our** conversation. If **You** need to let **Us** know about any changes in **Your** personal circumstances, **You** can do so using the contact details below.

Our UAE team is available Sunday to Thursday from 9am to 5pm. Thereafter **Our** other customer service teams are available 24-hours a day.

T +971 (0) 4450 1415 | F +971 (0) 4450 1416 | CustomerService@now-health.com

Arabia Insurance Company S.A.L., c/o Now Health International Gulf Third Party Administrators LLC, 2348 Sky Tower, Al Reem Island, PO Box 132168, Abu Dhabi, UAE.

Unit 3701, Burj Al Salam Building, 3 Sheikh Zayed Rd, PO Box 334337, Dubai, United Arab Emirates

Assistance team for Emergency Evacuation or Repatriation

Our multilingual team is available 24 hours a day, 365 days a year. For details on how to use **Our Emergency Evacuation** and **Repatriation** service see section 3.3.

T +971 (0) 4450 1456

If **You** have any questions about **Your** membership or would like to request information on the progress of a claim, **You** can log in to **Your** online secure portfolio at www.now-health.com or contact **Us** via email at ClinicalService@now-health.com.

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1. Definitions

The following words and phrases used anywhere within **Your Plan** have specific meanings. They are always shown in bold with a capital letter at the beginning wherever they appear in **Your Plan**.

Accident	A sudden, unexpected, unforeseen and involuntary external event resulting in identifiable physical injury occurring to an Insured Person while Your Plan is in force.
Acute Condition	A disease, illness or injury that is likely to respond quickly to Treatment which aims to return You to the state of health You were in immediately before suffering the disease, illness or injury, or which leads to Your full recovery.
Act of Terrorism	Any clandestine use of violence by an individual terrorist or a terrorist group to coerce or intimidate the civilian population to achieve a political, military, social or religious goal.
Alternative Therapies	Refers to therapeutic and diagnostic Treatment that exists outside the institutions where conventional medicine is taught. Such medicine includes Chinese medicine, chiropractic Treatment , osteopathy, dietician, homeopathy and acupuncture as practised by approved therapists.
Apicoectomy	Is a dental surgery performed to remove the root tip and the surrounding infected tissue of an abscessed tooth, when inflammation or infection persists in the bony area around the end of a tooth after a root canal procedure. Apicoectomy is done to treat the following:
	 Fractured tooth root A severely curved tooth root Teeth with caps or posts Cyst or infection which is untreatable with root canal therapy Root perforations Recurrent pain and infection Persistent symptoms that do not indicate problems from x-rays Calcification Damaged root surfaces and surrounding bone requiring surgery
Benefits	Insurance cover provided by this Plan and any extensions or restrictions shown in the Certificate of Insurance or in any endorsements (if applicable) and subject always to Us having received the premium due.
Benefit Schedule	The table of Benefits applicable to this Plan showing the maximum Benefits We will pay.
Cancer	A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
Certificate of Insurance	The certificate giving details of the Planholder , the Insured Persons , the Period of Cover , the Entry Date , the level of cover and any endorsements that may apply.
Congenital Disorder	A Medical Condition that is present at birth or is believed to have been present since birth, whether it is inherited or caused by environmental factors.
Co-Insurance	Is the uninsured percentage of the costs, which the Insured Person must pay towards the cost of a claim.
Country of Nationality	The country for which You hold a passport and as You declared to Us .
Country of Residence	The country in which You habitually reside (usually for a period of no less than six months per Period of Cover) at the Plan Start Date or Entry Date or at each subsequent Renewal Date .

Chronic Condition	 A disease, illness or injury which has at least one of the following characteristics: It needs ongoing or long-term monitoring through consultations, examination, check-ups, Drugs and Dressings and/or tests It needs ongoing or long-term control or relief of symptoms It requires Your Rehabilitation or for You to be specially trained to cope with it It continues indefinitely It has no known cure It comes back or is likely to come back
Day-Patient	A patient who is admitted to a Hospital or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.
Deductible (Please note that an annual Deductible is not available to residence visa holders in the Emirates of Dubai or Abu Dhabi)	An uninsured amount payable by an Insured Person in respect of In-Patient and Day-Patient expenses incurred before any Benefits are paid under the Plan , as specified in Your Certificate of Insurance . The Plan Deductible applies per Insured Person , per Period of Cover .
Dental Practitioner	A person who is legally licensed to carry out this profession by the relevant licensing authority to practise dentistry in the country where the dental Treatment is given and recognised by Us .
Dependants	One spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with You , or up to 28 years old if in full-time education (written proof may be required from the educational institute where they are enrolled), at the Start Date or any subsequent Renewal Date . The term partner shall mean husband or wife, living with You . All Dependants must be named as Insured Persons in the Certificate of Insurance .
Diagnostic Tests	Investigations, such as x-rays or blood tests, to find or to help to find the cause of Your symptoms.
Drugs and Dressings	Essential prescription drugs, dressings and medicines, which are authorised and recognised in the country where they are prescribed and are administered by a Medical Practitioner or Specialist needed to relieve or cure a Medical Condition .
Eligible	Those Treatments and charges, which are covered by Your Plan . In order to determine whether a Treatment or charge is covered, all sections of Your Plan should be read together, and are subject to all the terms (including payment of premium due), Benefits and Exclusions set out in this Plan .
Entry Date	The date shown on the Certificate of Insurance on which an Insured Person was included under this Plan .
Emergency	A sudden, serious, and unforeseen acute Medical Condition or injury requiring immediate medical Treatment , that without Treatment commencing within 48 hours of the emergency event could result in death or serious impairment of bodily function.
Evacuation or Repatriation Service	Moving You to a Hospital which has the necessary In-Patient and Day-Patient medical facilities either in the country where You are taken ill or in another nearby country (evacuation) or bringing You back to either Your principal Country of Nationality or Your principal Country of Residence (repatriation). The service includes any Medically Necessary Treatment administered by the international assistance company appointed by Us while they are moving You.
Expatriate	Any persons living and/or working outside of the country for which they hold a passport. Usually for a period of more than 180 days per Period of Cover .
Geographic Area	The geographic area used to calculate the premium that will apply to You based on Your principal Country of Residence at the Start Date or any subsequent Renewal Date of this Plan .

Hospital	Any establishment, which is licensed as a medical or surgical hospital under the laws of the country where it operates. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.
Hospital Accommodation	Refers to standard private or semi-private accommodation as indicated in the Benefit Schedule . Deluxe, executive rooms and VIP suites are not covered.
In Network Medical Provider	Is a medical facility recognised by Us and contracted by Us and provides medical services to Plan members for specific pre-negotiated rates agreed by Us .
In-Patient	A patient who is admitted to Hospital and who occupies a bed overnight or longer, for medical reasons.
Insured Person/You/Your	The Planholder and/or the Dependants named on the Certificate of Insurance who are covered under this Plan .
Medical Condition	Any disease, injury, or illness, including Psychiatric Illness.
Medical Practitioner	A person who has attained primary degrees in medicine or surgery following attendance at a WHO -recognised medical school and who is licensed to practise medicine by the relevant authority in the country where the Treatment is given. By "recognised medical school" We mean a medical school, which is listed in the current World Directory of Medical Schools published by the WHO .
Medical Provider Agreement	An agreement We have with each of the Hospitals , Day-Patient units and scanning centres listed in the Now Health International Provider Network .
Medically Necessary	Treatment , which in the opinion of a qualified Medical Practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the Insured Person's condition or the quality of medical care rendered. Such Treatment must be required for reasons other than the comfort or convenience of the patient or Medical Practitioner and provided only for an appropriate duration of time. As used in this definition, the term "appropriate" shall mean 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.
New Born	A baby who is within the first 16 weeks of its life following birth.
Now Health International Provider Network	Our published list of medical providers where We have a Direct Billing Agreement . A separate list of medical providers will be available for residents in the Emirate of Abu Dhabi.
Out-Patient Per Visit Excess	An Uninsured amount payable by an Insured Person in respect of Out-Patient expenses before any Benefits are paid under the Plan as specified in Your Certificate of Insurance . Each visit refers to each consultation. The Out-Patient Per Visit Excess applies per Insured Person , per Out-Patient consultation, when You receive Eligible Out-Patient Treatment inside and outside of the Now Health International Provider Network .
Out of Network Medical Provider	An out of network medical provider is one not contracted with Your Plan.
Out-Patient	A patient who attends a Hospital , consulting room, or out-patient clinic and is not admitted as a Day-Patient or an In-Patient .

Out Datiant Direct Billing	Our published list of medical providers where We have a Direct Billing
Out-Patient Direct Billing	Our published list of medical providers where We have a Direct Billing Provider Network.
Period of Cover	The period of cover set out in the Certificate of Insurance . This will be a 12-month period starting from the Start Date or any subsequent Renewal Date as applicable.
Physiotherapist	A practising physiotherapist who is registered and licensed to practise in the country where Treatment is provided.
Pre-Authorisation	A process whereby an Insured Person seeks approval from Us prior to undertaking any Treatment or incurring costs. Such Benefits requiring pre-authorisation from Us will denote Pre-Authorisation a in the Benefit Schedule and as detailed in section 4.
Plan	The contract between You and Us which set out terms and conditions of the cover provided. The full terms and conditions consist of the application form, Certificate of Insurance, Benefit Schedule and this members' handbook.
Planholder	The person or company named as planholder in the Certificate of Insurance .
Pregnancy	Refers to the period of time from the date of the first diagnosis until delivery.
Private Room	Single occupancy accommodation in a private Hospital . Deluxe, executive rooms and VIP suites are not covered.
Psychiatric Illness	The mental or nervous disorder that meets the criteria for classification under an international classification system such as Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation.
Qualified Nurse	A nurse whose name is currently on any register or roll of nurses, maintained by any Statutory Nursing Registration Body within the country where Treatment is provided and recognised by Us .
Reasonable and Customary Charges	The standard fee that would typically be made in respect of Your Treatment costs, in the country You received Treatment . We may require such fees to be substantiated by an independent third party, such as a practising Surgeon/ Physician/ Specialist or government health department.
Rehabilitation	Medically Necessary Treatment aimed at restoring independent activities of daily living and the normal form and/or function of an Insured Person following a Medical Condition.
Renewal Date	The anniversary of the Start Date of the Plan .
Restricted Network	Our published list of restricted medical providers where We have a Direct Billing Provider Network Agreement.
Semi-Private Room	Dual occupancy accommodation in a private Hospital . Deluxe, executive rooms and VIP suites are not covered.
Specialist	A surgeon, anaesthetist or physician who has attained primary degrees in medicine or surgery following attendance at a WHO -recognised medical school and who is licensed to practise medicine by the relevant authority in the country where the Treatment is given, and is recognised as having a specialised qualification in the field of, or expertise in, the Treatment of the disease, illness or injury being treated. By "recognised medical school" We mean a medical school which is listed in the current World Directory of Medical Schools published by the WHO .

Start Date	The start date shown on Your Certificate of Insurance . We must have received premium payment in order for Your contract to start.
Surgical Procedure	An operation requiring the incision of tissue or other invasive surgical intervention.
Terminal	Following the diagnosis that the condition is terminal and Treatment can no longer be expected to cure the condition with death anticipated within 12 months of diagnosis.
Treatment	Surgical or medical services (including Diagnostic Tests) that are needed to diagnose, relieve or cure a Medical Condition .
Vaccinations	Refers to all basic immunisations and booster injections required under regulation of the country in which Treatment is being given, any Medically Necessary travel vaccinations and malaria prophylaxis.
Waiting Period	Is a period of time starting on Your Plan Start Date (or Entry Date if You are a Dependant), during which You are not entitled to cover for particular Benefits . Your Benefit Schedule will indicate which Benefits are subject to waiting periods.
We/Our/Us	Arabia Insurance Company S.A.L.
WHO	The World Health Organisation.

2. Manage your plan online

A guide to the secure online portfolio area

The simplest way to manage **Your Plan** is via the secure online portfolio area which **You** can access at www.now-health.com. To access it **You** need the unique username and password **You** were supplied with when **You** joined. If **You** need help to retrieve this information, contact **Us** on +971 (0) 4450 1415.

About me

In this section **You** can view and update **Your** personal contact and login details, **Your** document delivery settings and tell **Us** how **You** would like **Us** to pay **Your** claims.

My Plan

You can view Your Plan details and download Your Certificate of Insurance, members' handbook and claim form from here. You can order replacement membership cards and view Your Benefit limits.

Your Claims

Here **You** can make a claim online and track **Your** claims in real time. **You** can view information about all **Your** claims, past and present, including claim status, the medical provider and the amounts claimed and settled, in the currency **You** have selected. All updates are displayed as they happen so **You** always have the latest information. **You** can also submit a **Pre-Authorisation** request from here.

Other features

In addition to the above, **You** can use the secure online portfolio to download forms, introduce **Us** to **Your** preferred intermediary or medical provider and find a medical provider in the **Now Health International Provider Network.**

For more information, visit the FAQ section of the website, which **You** can access from **Our** homepage www.now-health.com.

Download our mobile app

Our mobile app, which is available for both iPhone and Android has many useful functions including the ability to find a medical provider with the **Now Health International Provider Network** and submit a claim for **Treatment You** have already paid for in a few simple touches.



3. How to claim

As soon as **You** become a customer, **You** can contact **Our** Customer Service team for support. **You** also have access to **Our** Helpline, which is open 24 hours a day, 365 days a year.

Your online secure portfolio area has a dedicated claims section with the latest information on past and present claims. **You** can also use this area to make a claim.

To log in, You just need Your username and password.

To help **Us** process **Your** claim as quickly as possible, please follow these simple steps:

3.1 Claiming for Treatment You have already paid for

Step 1

Choose how You would like to claim

You can claim using the secure online portfolio at www.now-health.com, the mobile app or if You prefer a more traditional solution, You can send Us a claim form using email, fax or post.

You can download a claim form from the secure online portfolio or the 'How to claim' page of www.now-health.com. Alternatively call **Us** on +971 (0) 4450 1415 to request a form or if **You** need help to access the secure online portfolio area.

Step 2

For all Out-Patient claims and In-Patient/ Day-Patient claims under USD 500 per Medical Condition:

Using the claim form (printed or pdf):

Complete sections 1 and 2, sign it and send it to **Us** with the receipt(s) and any other relevant information such as diagnostic reports, discharge reports and medical reports.

- Email to ClaimsService@now-health.com, or
- Fax to +971 (0) 4450 1416, or
- Post to Now Health International Gulf Third Party Administrators LLC, Unit 3701, Burj Al Salam Building, 3 Sheikh Zayed Rd, PO Box 334337, Dubai, United Arab Emirates

Using the mobile app:

Complete all the fields in the form, upload the requested images, accept the declaration and authorisation and click 'Submit'. **We** will save the information **You** include in **Your** settings.

Using the secure online portfolio:

Select the **Insured Person** from the dropdown list, complete all the fields in the form, upload the requested images, accept the declaration and authorisation and click 'Submit form'.

Step 2

For In-Patient/Day-Patient claims over USD 500 per Medical Condition:

Using the claim form (printed or pdf):

You and Your Medical Practitioner must complete all the relevant sections before You submit Your claim. Sign the claim form and send it to Us with the receipt(s) and any other relevant information such as diagnostic reports, discharge reports and medical reports.

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- Email to ClaimsService@now-health.com, or
- Fax to +971 (0) 4450 1416, or
- Post to Now Health International Gulf Third Party Administrators LLC, Unit 3701, Burj Al Salam Building, 3 Sheikh Zayed Rd, PO Box 334337, Dubai, United Arab Emirates

Using the mobile app:

You cannot use the mobile app to submit a claim of this value.

Using the secure online portfolio:

Scan the completed claim form and upload it along with the receipt(s) and any other relevant information such as diagnostic reports, discharge reports and medical reports, and click 'Submit form'.

Step 3

We will assess Your claim. Provided We have all the information We need, We will process all Eligible claims within five working days of receipt.

Step 4

You can track all Your claims using Your online secure portfolio area. Log in at any time using Your username and password to see how Your claim is progressing. You will be able to view the status, the medical provider, the currency claimed and settled and the **Benefit** for each individual claim, as well as any **Deductible**, Co-Insurance or Out-Patient Per Visit Excess applied. All updates are displayed as they happen so You always have the latest information on Your claims. We will email or SMS You every time there is a change to the claims status on Your account so You know the most relevant time to log in.

Important notes:

You must send Us Your claim within six months of Treatment (unless this is not reasonably possible).

Please keep original records if **You** are sending **Us** a copy, as **We** may ask **You** to forward these at a later date. If **We** do, it will be within six months of when **You** told **Us** about the claim.

If the total amount You are claiming now or have claimed for Day-Patient and In-Patient (per Insured Person, per Medical Condition, per Period of Cover) is over USD 500, please ensure Section 3 of the claim form is completed by the treating Medical Practitioner.

If **You** don't know if **Your** claim falls within the USD 500 per **Medical Condition** guideline, please complete all sections of the claim form and ask **Your Medical Practitioner** to complete their section send it to **Us** to using one of the options in Step 2.

For all claims where **We** reimburse **You**, **You** can choose which currency **You** would like **Your** claims to be settled in and how **You** would like them to be paid.

Please note that the above process applies to claims against both the maternity, dental and wellness, optical and **Vaccinations** Benefits, should You have opted for a Plan with those Benefits.

3.2 Arranging Direct Settlement

3.2.1 For In-Patient and Day-Patient Treatment

If **You** are referred for **In-Patient** or **Day-Patient Treatment**, **We** will try to arrange to settle the bill directly with the medical provider.

Step 1

Five working days before **You** are admitted (or whenever possible), contact **Our** customer service team on T +971 (0) 4450 1415 | F +971 (0) 4450 1416 | ClinicalService@now-health.com

Tell Us the Hospital name, telephone number, fax number, the contact name at the Hospital and the name of the Medical Practitioner.

Step 2

Your Medical Practitioner should complete a **Pre-Authorisation** Request Form. You can download this form from the 'How to claim' page of the website or from the secure online portfolio area.

Once **Your Medical Practitioner** has completed the form, they can return it to **Us** directly or **You** can do so using one of the methods on the form or using the secure online portfolio area in the My Claims page.

We will contact You once the arrangements have been made.

Step 3

When You arrive at the medical provider on the day of Your Treatment, show Your membership card and tell them that Direct Billing has been arranged.

We may also ask You to fill in some extra forms, such as a release of medical information by the medical provider. You can access all the forms You need from Your online secure portfolio area at www.now-health.com.

You will need to pay any Deductible on Your Plan to the medical provider before You leave.

Step 4

When You leave, ask the medical provider to send the original claim form and bill to Us for payment. You can track all subsequent claims activity in Your online secure portfolio area. Log in using Your username and password at www.now-health.com.

Important notes:

For In-Patient Treatment, Day-Patient Treatment or major Out-Patient Treatment, please contact Us before You get Treatment. If You don't make contact before Your admission, We may not be able to arrange to pay the medical provider directly. This might mean that You have to pay a deposit to the medical provider or pay Your bill in full.

If You need repeat In-Patient or Day-Patient Treatment, We need a new claim form for each stay, even if it's for the same Medical Condition.

You will need to pay any Deductible on Your Plan to the medical provider before You leave.

3.2 Arranging Direct Settlement

3.2.2 Out-Patient Treatment within the Now Health International Direct Billing Network – The following process applies for Insured Persons with Residence visas in the Emirates of Dubai or Abu Dhabi

Your Eligible Out-Patient Treatment is subject to any selected Out-Patient Per Visit Excess option or Co-Insurance Out-Patient Treatment option.

If You have selected an Out-Patient Per Visit Excess option, You need to pay the first USD 25 or USD 15 (depending on the option chosen) per consultation on Eligible Out-Patient Treatment to the medical provider upfront through Our Out-Patient Direct Billing Network. If You have this option, it will say so on Your Membership card.

Step 1

To find an **Out-Patient Direct Billing** facility, log in to **Your** online secure portfolio area at www.now-health.com or use the mobile app. Here **You** can locate an appropriate medical facility or **Restricted Network** facility within the **Out-Patient Direct Billing** Network or **Restricted Network**.

If You can't find an Out-Patient Direct Billing facility near You, Our customer service team will be happy to help. You can contact them on T +971 (0) 4450 1415 | F +971 (0) 4450 1416 | ClinicalService@now-health.com

Step 2

When **You** arrive at the medical facility, please show **Your** Now Health membership card. Please also take a form of identification such as an ID card or passport. The medical facility may ask **You** to complete and sign an authorisation form or disclaimer.

Step 3

The medical facility will check **Out-Patient Per Visit Excess** and any **Co-Insurance** before arranging for **You** to see a doctor. If **Your** cover is not **Eligible**, they will still arrange for **You** to see a doctor but will ask **You** to pay for the **Treatment**.

Step 4

When You leave, the medical facility may ask You to sign a confirmation that You have received Treatment.

Step 5

If You need to return for further Treatment, You will have to complete the same procedure again.

Important notes:

If You receive Treatment that is not Eligible under Your Plan through the Now Health International Provider Network, You are liable for the costs incurred and You must refund Us or We may suspend Your Benefits until the Planholder or You have settled the outstanding amounts in full. If We determine that a claim was fraudulent, We may terminate You from the Plan with immediate effect without refund of premiums.

If You were Eligible Treatment within the Now Health International Provider Network but pay and claim for the Treatment received, the standard Out Patient Per Visit Excess will apply.

Out-Patient Direct Billing is not available for dental, wellness, optical and Vaccinations Benefits.

We offer Direct Billing for maternity if You have the optional maternity **Benefit** on Advance, Excel or Apex **Plan**. If **You** choose the maternity **Benefit** with **Out-Patient Direct Billing**, it will be specified on **Your** Membership Card.

However, You have to pay and claim for Dubai Health Authority (DHA) Mandatory requirements maternity Benefit.

For Dubai resident visa holders seeking **Treatment** in the Emirate of Dubai, they will only be charged 20% up to their excess amount for **Out-Patient** consultations in the Emirate of Dubai.

A USD 15 Out-Patient Per Visit Excess is available for Insured Persons with residence visas in the Emirate of Abu Dhabi.

3.2 Arranging Direct Settlement

3.2.3 Out-Patient Treatment within the Now Health International Direct Billing Network – The following process applies for Insured Persons with Residence visas in the Emirates outside of Dubai or Abu Dhabi

If You have a Deductible this does not apply to Treatment You receive on an Out-Patient basis in Our Out-Patient Direct Billing Network.

Your Eligible Out-Patient Treatment is subject to any selected Out-Patient Per Visit Excess option or Co-Insurance Out-Patient Treatment option.

- If You have selected an Out-Patient Per Visit Excess option, You need to pay the first USD 25 or USD 15 (depending on the option chosen) per consultation on Eligible Out-Patient Treatment to the medical provider upfront through Our Out-Patient Direct Billing Network. If You have this option, it will say so on Your Membership card.
- If You have selected a Co-Insurance Out-Patient Treatment option, You must pay the Co-Insurance amount on Eligible Out-Patient Treatment to the medical provider upfront through Our Out-Patient Direct Billing Network.

If the **Out-Patient Per Visit Excess** or **Co-Insurance Out-Patient Treatment** is selected this will apply per **Insured Person** when **You** receive **Eligible Out-Patient Treatment** inside and outside of the **Now Health International Provider Network.**

Out-Patient Direct Billing is not available if You have chosen the WorldCare Essential Plan with the Out-Patient Charges option.

Step 1

To find an **Out-Patient Direct Billing** facility, log in to **Your** online secure portfolio area at www.now-health.com or use the mobile app. Here **You** can locate an appropriate medical facility within the **Out-Patient Direct Billing** Network. If **You** can't find an **Out-Patient Direct Billing** facility near **You**, **Our** customer service team will be happy to help. **You** can contact them on T +971 (0) 4450 1415 | F +971 (0) 4450 1416 | ClinicalService@now-health.com

Step 2

When You arrive at the medical facility, please show Your Now Health membership card. Please also take a form of identification such as an ID card or passport. The medical facility may ask You to complete and sign an authorisation form or disclaimer.

Step 3

The medical facility will check **Out-Patient Per Visit Excess** and any **Co-Insurance** before arranging for **You** to see a doctor. If **Your** cover is not **Eligible**, they will still arrange for **You** to see a doctor but will ask **You** to pay for the **Treatment**.

Step 4

When You leave, the medical facility may ask You to sign a confirmation that You have received Treatment.

Step 5

If You need to return for further Treatment, You will have to complete the same procedure again.

Important notes:

If You receive Treatment that is not Eligible under Your Plan through the Now Health International Provider Network, You are liable for the costs incurred and You must refund Us or We may suspend Your Benefits until the Planholder or You have settled the outstanding amounts in full. If We determine that a claim was fraudulent, We may terminate You from the Plan with immediate effect without refund of premiums.

If You receive Eligible Treatment within the Now Health International Provider Network but pay and claim for the Treatment received, the standard Out-Patient Per Visit Excess or Co-Insurance will apply.

Out-Patient Direct Billing is not available for dental, wellness, optical and Vaccinations Benefits unless it is specified on Your Membership Card.

3.3 When You need Emergency medical Treatment

If a Hospital admits You for Emergency medical Treatment or if the Hospital that is treating Your Emergency Medical Condition tells You that You need to be evacuated to another medical facility for Treatment, You, the treating Medical Practitioner or the Hospital, must contact Our 24 hour Emergency assistance service as soon as possible.

By contacting **Our Emergency** assistance service **You** will give **Us** the opportunity to arrange to settle **Your Hospital** bills directly where possible. It will also ensure that **Your** claim can be processed without any delays.

Step 1

Contact **Our Emergency** assistance service on +971 (0) 4450 1456 or email ClinicalService@now-health.com. This service is available 24 hours a day, 365 days a year.

They will need **Your** name and membership number as well as the **Hospital** name, telephone number and fax number, a contact name at the **Hospital** and the name of the **Medical Practitioner**.

Step 2

Our Emergency assistance service will verify whether the Medical Condition You are claiming for is Eligible under Your Plan.

Step 3

If Your claim is Eligible, Our Emergency assistance service staff will consider Your Emergency admission or Your request for Evacuation in relation to Your medical needs.

Step 4

If Our Emergency assistance service agrees that Your Medical Condition meets all of the following:

- is life-threatening
- is covered by Your Plan
- cannot be treated adequately locally, and
- requires immediate In-Patient Treatment

They will make all the necessary arrangements to have **You** moved by air and/or surface transportation to the nearest **Hospital** where appropriate medical **Treatment** is available.

Our Emergency assistance service will also ensure that any Eligible costs at the destination, such as admission costs, are settled directly with the Hospital.

Step 5

Once You have received Your medical Treatment, if Our Emergency assistance service agrees that it is necessary, they will make all the necessary arrangements to repatriate You to Your appropriate destination, provided that You are medically fit to travel.

Important notes:

We will only pay for **Evacuation** costs that have been authorised and arranged by **Our Emergency** assistance service.

We will not pay for Your Evacuation costs if the Evacuation is directly or indirectly related to a Medical Condition which has been specifically excluded on Your Certificate of Insurance, or to any other Medical Condition or event specifically excluded in Your Plan.

3.4 Accessing elective Treatment in the USA

If **You** have selected the USA Elective **Treatment** option and need referral to a **Medical Practitioner** or **Hospital** in the USA, please follow the steps below.

If **You** are referred for **Out-Patient** diagnostics and surgery, **Day-Patient** or **In-Patient Treatment** in the USA, **You** must contact **Us** as soon as **You** can. **We** will confirm that the facility is an **In Network Medical Provider** and will try to arrange to settle the bill directly with the medical provider. If the medical provider **You** have selected is out of network or does not provide **Your** requested services on direct billing, **We** will make arrangements to find an equivalent medical provider that is in network.

Step 1

Five working days before **Your Treatment** (or as early as possible), contact **Our** customer service team on T +971 (0) 4450 1415 | F +971 (0) 4450 1416 | ClinicalService@now-health.com

A Clinical Adviser will verify Your entitlement to Benefits for the proposed Treatment and give You details on how to claim.

Tell **Us** the name of the medical facility, telephone number, fax number, contact name and the name of the **Medical Practitioner**.

Step 2

Your Medical Practitioner should complete a **Pre-Authorisation** Request Form. You can download this form from the 'How to claim' page of the website or from the secure online portfolio area.

Once Your Medical Practitioner has completed the form, they can return it to Us directly or You can do so using one of the methods on the form or using the secure online portfolio area in the My Claims page.

We will contact You once the arrangements have been made.

Step 3

When You arrive at the medical provider on the day of Your Treatment, show Your membership card and tell the medical provider that We have arranged Direct Billing through Our agents.

We may also ask You to fill in some extra forms, such as an agreement that the medical provider can release information about You to Us. You can access all forms from Your online secure portfolio area at www.now-health.com.

You will need to pay any **Deductible**, Co-Insurance or Out-Patient Per Visit Excess on Your Plan to the medical provider before You leave.

Step 4

When **You** leave, ask the medical provider to send the original claim form and bill to **Us** for payment. **You** can track all subsequent claims activity on **Your** online secure portfolio area. Log in at www.now-health.com using **Your** username and password.

Important notes:

Please contact Us before You receive any In-Patient Treatment, Day-Patient Treatment or major Out-Patient Treatment. If You don't contact Us before Your admission, We may not be able to arrange to pay the medical provider directly. This might mean that You have to pay a deposit to the Hospital or pay Your bill in full.

If You go to an Out of Network Medical Provider, We will apply a Co-Insurance of 50% to any Eligible Treatment as per Your Benefit Schedule. You will be responsible for the difference, which You will have to pay directly to the Out of Network Medical Provider.

We reserve the right to refuse to cover any medical expenses that You incur in the USA that We have not authorised.

If We pay the medical provider directly for any Treatment that is not Eligible under Your Plan, You must refund the equivalent sum to Us.

You will need to pay any Deductible, Co-Insurance or Out-Patient Per Visit Excess on Your Plan to the medical provider before You leave.

3.5 What must I provide when making a claim?

Please make sure that You complete all the forms We ask You to.

You must send Us all Your claim information within six months of the first day of Treatment (unless this is not reasonably possible).

If the total amount **You** are claiming now or have claimed for **Day-Patient** and **In-Patient** (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500, please ensure Section 3 of the claim form is completed by the treating **Medical Practitioner**.

3.6 Do I need to provide any other information?

It may not always be possible to assess the eligibility of **Your** claim from the claim form alone, which means **We** may sometimes ask **You** for additional information. This will only ever be reasonable information that **We** need to assess **Your** claim.

We may request access to Your medical records including medical referral letters. If You don't reasonably allow Us access to this important information, We will have to refuse Your claim. This means that We will also recoup any previous payments that We have made for that Medical Condition. There may be instances where We are uncertain about the eligibility of a claim. If this is the case, We may, at Our own cost, ask a Medical Practitioner chosen by Us to review the claim. They may review the medical facts relating to a claim or examine You in connection with the claim. In choosing a relevant Medical Practitioner, We will take into account Your personal circumstances. You must co-operate with any Medical Practitioner chosen by Us or We will not pay Your claim.

3.7 What should I do if I also have cover on another insurance policy?

If **You** are making a claim, **You** must tell **Us** if **You** are able to claim any costs from another insurance policy. If another insurance policy is involved, **We** will only pay **Our** proper share.

3.8 What should I do if the Benefits I am claiming relate to an injury or Medical Condition caused by another person?

You must tell Us on the claim form if You are able to claim any of the cost from another person.

If **You** are claiming for **Treatment** for a **Medical Condition** caused by another person, **We** will still pay for **Benefits** that **You** can claim under the **Plan**.

If **You** are claiming for **Treatment** for an injury caused by another person, **We** obtain the right by law, to recover the sum of the **Benefits** paid from the other person. **You** must tell **Us** as quickly as possible about any action against another person and keep **Us** informed of any outcome or settlement of this action.

Should **You** successfully recover any monies from the third party, they should be repaid directly to **Us** within 21 days of receipt on the following basis:

- if the claim against the third party settles in full, You must repay Our outlay in full; or
- if **You** recover only a percentage of **Your** claim for damages **You** must repay the same percentage of **Our** outlay to **Us**.

If **You** do not repay **Us** (including any interest recovered from the third party), **We** are entitled to recover the same from **You**. In addition, **Your Plan** may be cancelled in line with section 8 in the Rights and Responsibilities section.

The rights and remedies in this clause are in addition to and not instead of rights or remedies provided by law.

3.9 You have a Deductible, an Out-Patient Per Visit Excess and/or Co-Insurance on Your Plan

Any **Deductible**, **Out-Patient Per Visit Excess** or **Co-Insurance** applicable is shown on **Your Certificate of Insurance** and charged in the same currency as **Your** premium.

A **Deductible**, an **Out-Patient Per Visit Excess** or **Co-Insurance** is the amount **You** pay towards the cost of a claim for any **Insured Person** on **Your Plan**.

When a claim is made, any **Deductible** is automatically deducted from the amount **We** pay in relation to **Eligible In-Patient** or **Day-Patient Treatment** first.

The **Deductible** applies per **Insured Person** per **Period of Cover**. For example, if an **Insured Person** claims more than once for **In-Patient Treatment** during one **Period of Cover**, the **Deductible** will only apply to the first **Eligible In-Patient** claim if the full **Deductible** amount has already been fulfilled on the first claim. If the **Deductible** has not been fulfilled after the first claim, the **Deductible** balance will be taken from the second claim before any **Eligible** claim amount is paid. Please note that **Deductibles** are not available for any **Insured Person** with residence visas in the Emirates of Dubai or Abu Dhabi.

The **Out-Patient Per Visit Excess** applies per **Insured Person**, per **Out-Patient** consultation in relation to **Eligible Out-Patient Treatment**. For example, if an **Insured Person** has more than one visit in relation to **Out-Patient** consultations for a single or multiple **Medical Condition** (s) then the **Out-Patient Visit Excess** will be applied to each consultation. The exception to this is if **You** have an initial consultation and **You** are asked to return for a further consultation and **You** are not charged for the second consultation, the **Out-Patient Per Visit Excess** will not apply to the free consultation.

A **Co-Insurance** is a percentage payment made by **You** towards the cost of an **Eligible** claim per **Period of Cover**. For example, if an **Insured Person** has 20% **Co-Insurance** applicable on **Out-Patient Treatment** and the claimed amount is USD 100, then the **Insured Person** will have to pay USD 20 and **We** will pay USD 80 towards the claim. Please note that this is not available for **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

You will need to submit Your Claim Form and bills, even if the **Deductible** or **Out-patient Per Visit Excess** is greater than the **Benefits You** are claiming so **We** can administer **Your Plan** correctly. When **You** make a claim, **We** will reduce the amount **We** pay **You** until the **Deductible** or **Out-Patient Per Visit Excess** limit is used up.

3.10 How will claim reimbursements be calculated?

Claims reimbursements will in all cases be based on the date of **Treatment**, and in the first instance will be paid in the same currency as the claim invoice. Alternatively, the currency of the **Plan** may be requested or **We** will endeavour to pay in another currency of **Your** choice. **We** will convert currencies based on the exchange rates quoted by Citibank as of the **Treatment** date.

3.11 What currencies can claims be made in?

You have the choice of claims reimbursement in either the currency of Your Plan, the currency You incurred Your claim in, or another currency of Your choice, subject to local currency and/or international restrictions/regulations and our partners bank's transacting capabilities.

4. Benefits: What is covered?

All the **Benefits** covered by WorldCare are shown in the **Benefit Schedule** in this section. The **Benefit** limits are per **Insured Person** and either per **Medical Condition**, per visit or per **Period of Cover**, with lifetime limits in place for **Terminal** illness.

Please remember that this **Plan** is not intended to cover all eventualities.

In return for payment of the premium, **We** agree to provide cover as set out in the terms of this **Plan**. Please refer to the definition of **Plan** in section 1 for details of the documents that make up **Your Plan**.

4.1 Summary of WorldCare

WorldCare has been designed to provide cover for **Reasonable and Customary Charges** for **Medically Necessary** and active **Treatment** of disease, illness or injury.

WorldCare provides worldwide cover, excluding the USA, unless the USA elective **Treatment** option is selected. A summary of each **Plan** is shown below:

Essential	Cover for In-Patient and Day-Patient Treatment , and the option for a Deductible to lower Your premiums, if You want to cover high cost/low frequency major medical events only. WorldCare Essential is not available to Insured Persons with residence visas in the Emirate of Abu Dhabi.
Advance	Cover for In-Patient, Day-Patient and Out-Patient Treatment.
Excel	As with Advance, and cover for dental and generally higher Plan limits.
Apex	As with Excel, and cover for dental and maternity, as well as Benefits with overall higher limits.
Optional Benefits To provide extra flexibility, You	can also select additional optional Benefits that might be important to You .
Cover options available are: USA Elective Treatment	Costs associated with Eligible In-Patient , Day-Patient and Out-Patient Treatment in the USA will be paid in full where Treatment is received in Our Network of Providers.
Co-Insurance Out-Patient Treatment	If this option is selected, costs associated with Eligible Out-Patient Treatment are subject to a 10% Co-Insurance (not available to Insured Persons with residence visas in the Emirate of Abu Dhabi).
Co-Insurance Out-Patient Treatment – Option 2	If this option is selected, costs associated with Eligible Out-Patient Treatment are subject to a 20% Co-Insurance (not available to Insured Persons with residence visas in the Emirate of Abu Dhabi).
Wellness, Optical and Vaccinations	This is an option available for Advance, Excel and Apex Plan options that allows you to receive limited cover for Wellness, Optical and Vaccinations .
Wellness, Optical and Vaccinations – Option 2	As with Wellness, Optical and Vaccinations with higher overall limits.
Your choice of Plan Deductible	The Plan Deductible applies to In-Patient and Day-Patient Treatment and is per Insured Person, per Period of Cover.
Out-Patient Per Visit Excess	This option is available for Advance, Excel and Apex. You can elect to pay a USD 25 or USD 15 Excess every time You visit an Out-Patient Medical Practitioner . Please note that if You have selected the Out-Patient Per Visit Excess , You must pay the first USD 25 or USD 15 of any Eligible Out-Patient claim. (Please note that USD 25 Excess is not available to Insured Persons with residence visas in the Emirate of Abu Dhabi).
Out-Patient Charges (Essential only)	Add Out-Patient Benefits to the Essential Plan option (not available to Insured Persons with residence visas in the Emirate of Abu Dhabi).
Out-Patient Charges – Option 2 (Essential only)	The same as Out-Patient Charges but inclusive of Maintenance of Chronic Medical Conditions within the Benefit sub-limit (not available to Insured Persons with residence visas in the Emirate of Abu Dhabi).

The above is a summary of just some of the **Plan Benefits**. For full details of the **Benefits** and exclusions, it is important that **You** read this handbook in full. For the full **Benefit Schedule**, please go to section 4.3.

4.2 Pre-Authorisation

When You should contact Us before Treatment starts.

Your Plan with Us will only cover Reasonable and Customary Charges for Treatment that is Medically Necessary. It is important that You contact Us before Treatment for Us to confirm if such Treatment is Eligible under Your Plan.

Pre-Authorisation is therefore required before undertaking **Treatment** and incurring charges. The **Benefit Schedule** details those **Benefits** requiring **Pre-Authorisation** by showing "**Pre-Authorisation 2**".

You should contact Our customer service team on +971 (0) 4450 1415 | Fax +971 (0) 4450 1416.

Pre-Authorisation means all costs under this **Benefit** require **Pre-Authorisation** from **Us**, which may or may not be included in **Your Plan**.

Pre-Authorisation is required for the following:

- All In-Patient Treatment
- All pre-planned Day-Patient Treatment
- All pre-planned surgery
- Diagnostic Procedures positron emission tomography (PET) scans
- In-Patient Psychiatric Treatment
- Evacuation and Repatriation
- Mortal Remains
- Physiotherapy for the Advance, Excel and Apex Plan options after every 10 sessions
- Nursing Care at home
- AIDS
- USA elective Treatment

If **Pre-Authorisation** is not obtained and **Treatment** is received and is subsequently proven not to be **Medically Necessary**, **We** reserve the right to decline **Your** claim. If **Treatment** is **Medically Necessary**, but **You** did not obtain **Pre-Authorisation**, **We** will only pay up to **Reasonable and Customary Charges**. By **Reasonable and Customary Charges**, **We** mean the standard fee that would be typically made in respect of **Your Treatment**.

In the case of any **Emergency**, **You**, the treating **Medical Practitioner** or the **Hospital**, must contact **Our** 24 hour **Emergency** assistance service as soon as possible. Failure to obtain **Pre-Authorisation** for **Treatment** of an **Eligible Medical Condition** means **You** may incur a proportion of the costs.

4.3 The WorldCare Plan

WorldCare has been designed to provide cover for **Reasonable and Customary Charges** for **Medically Necessary** and active **Treatment** of disease, illness or injury. The **Benefit Schedule** below details the cover provided by each **Plan**. This is additional information that should be read in conjunction with this complete handbook.

Benefits aim to cover short term **Treatment** of acute episodes of **Chronic Conditions**, to return **You** to the state of health **You** were in immediately before suffering the episode, or which leads to a full recovery. If this is not possible and maintenance therapy of a **Chronic Condition**, such as but not limited to asthma, diabetes, and hypertension, is required, such cover will be provided by **Benefit** 1 – Maintenance of Chronic **Medical Conditions**. If **You** are unsure of **Your** particular circumstances, please contact **Our** Customer Service team before incurring any **Treatment** costs. Some cover states "Full Refund" and this means that **Eligible** claims are covered up to the annual maximum **Plan** limit, after any deduction of any **Deductible**, **Out-Patient Per Visit Excess** or **Co-Insurance** or similar condition, if **Reasonable and Customary Charges** for **Medically Necessary Treatment** are incurred.

4.3.1 WorldCare Essential

(not available to Insured Persons with residence visas in the Emirate of Abu Dhabi)

Re	enefit	Essential
	nnual Maximum Plan Limit /7 helpline and assistance services available on all Plans	USD 3m
1.	Maintenance of Chronic Medical Conditions: Maintenance of chronic Medical Conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, examinations, check-ups, Drugs and Dressings and/or tests up to the Benefit limits following Your Entry Date. This Benefit does not cover renal failure and dialysis. Claims for this will fall under Benefit 6. Claims for Cancer will fall under Benefit 8.	Not covered
2.	 Hospital Charges, Medical Practitioner and Specialist Fees: (i) Charges for In-Patient or Day-Patient Treatment made by a Hospital including charges for accommodation (ward/semi-private or private); Diagnostic Tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a Qualified Nurse; Drugs and Dressings prescribed by a Medical Practitioner or Specialist; and surgical appliances used by the Medical Practitioner during surgery. This includes pre and post-operative consultations while an In-Patient or Day-Patient and includes charges for intensive care. (ii) Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propelled 	(i) Full refund Pre-Authorisation for (i)
3.	non-electronic wheelchairs within six months of an Eligible Medical Condition which required In-Patient or Day-Patient Hospital Treatment . Diagnostic Procedures:	Up to USD 1,500 pe Medical Condition Pre-Authorisation
	Medically Necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an In-Patient, Day-Patient or Out-Patient.	for PET 🕿 Full refund
4.	Emergency Ambulance Transportation: Emergency road ambulance transport costs to or between Hospitals, or when considered Medically Necessary by a Medical Practitioner or Specialist.	Full refund
5.	Parent Accommodation: The cost of one parent staying in Hospital overnight with an Insured Person under 18 years old while the child is admitted as an In-Patient for Eligible Treatment.	Full refund
6.	Renal Failure and Renal Dialysis: (<i>i</i>) <i>Treatment</i> of renal failure, including renal dialysis on an <i>In-Patient</i> basis.	(i) Full refund for In- Patient pre and pos operative care
	(ii) Treatment of renal failure, including renal dialysis on a Day-Patient or Out-Patient basis.	(ii) Not covered
7.	 Organ Transplant: (i) Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the Insured Person as a recipient. In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Benefit 12 but excluded from Benefit 7 – Organ Transplant. (ii) Medical costs associated with the donor as an In-Patient or Day-Patient, with the exception of the cost of the donor organ search. We only pay for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with 	 (i) Full refund (ii) Up to USD 50,000 per Period of Cove
	WHO quidelines.	

Be	enefit	Essentia
9.	 Pregnancy and Childbirth Medical Conditions: In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. As an illustration, We would consider Treatment of the following: Ectopic Pregnancy (where the foetus is growing outside the womb) Hydatidiform mole (abnormal cell growth in the womb) Retained placenta (afterbirth retained in the womb) Placenta praevia Eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia) Diabetes (If You have exclusions because of Your past medical history which relate to diabetes, then You will not be covered for any Treatment for diabetes during Pregnancy) Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth) Miscarriage requiring immediate surgical Treatment 	Full refund
10.	New Born Cover: In-Patient Treatment of premature birth (i.e. prior to age 37 weeks gestation) or an Acute Condition being suffered by a New Born baby of an Insured Person which manifests itself within 30 days of birth and premium paid. Cover for multiple births will be covered up to the same limits shown. In circumstances where We require details of the New Born baby's medical history before the baby is being added to the Plan, We reserve the right to apply particular restrictions to the cover We will offer. Please refer to Section 6.5 - Adding New Born of this Members' Handbook for details.	Up to USD 100, per Period of Co
11.	Hospital Accommodation for New Born Accompanying their Mother: Hospital Accommodation costs relating to a New Born baby (up to 16 weeks old) to accompany its mother (being an Insured Person) while she is receiving Eligible Treatment as an In-Patient in a Hospital.	Full refund
12.	Congenital Disorder: In-Patient Treatment for a Congenital Disorder. In circumstances where a Congenital Disorder manifests itself in a New Born baby within 30 days of birth, cover for such Medical Conditions will be provided under Benefit 10 but excluded from Benefit 12 – Congenital Disorders.	Up to USD 100, per Period of C
13.	Reconstructive Surgery: Reconstructive surgery required to restore natural function or appearance following an Accident or following a Surgical Procedure for an Eligible Medical Condition, which occurred after an Insured Person's Entry Date or Start Date whichever is later.	Full refund
14.	Rehabilitation: When referred by a Specialist as an integral part of Treatment for a Medical Condition necessitating admission to a recognised Rehabilitation unit of a Hospital. Where the Insured Person was confined to a Hospital as an In-Patient for at least three consecutive days, and where a Specialist confirms in writing that Rehabilitation is required. Admission to a Rehabilitation unit must be made within 14 days of discharge from Hospital. Such Treatment should be under the direct supervision and control of a Specialist and would cover: (i) Use of special Treatment rooms (iii) Speech therapy fees (iv) Occupational therapy fees	Full refund for Eligible In-Patient Treatment or up to 30 days p Medical Condit
15.	 In-Patient Emergency Dental Treatment: This means Emergency restorative dental Treatment required to sound, natural teeth following an Accident which necessitates Your admission to Hospital for at least one night. The dental Treatment must be received within 10 days of the Accident. This Benefit covers all costs incurred for Treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply: If the Treatment involves replacing a crown, bridge facing, veneer or denture, We will pay only the reasonable and customary cost of a replacement of similar type or quality. If implants are clinically needed We will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead This Benefit also covers repair or reconstruction of dentures broken following an Accident that necessitates the Insured Person's admission to a Hospital for at least one night, provided that such dentures were being worn at the time of the Accident. 	Full refund
16.	In-Patient Psychiatric Treatment: In-Patient Treatment in a recognised Psychiatric unit of a Hospital. All Treatment must be administered under the direct control of a Registered Psychiatrist.	Pre-Authorisation

Full refund

Not covered

Subject to limits

Optional

Benefit

17. Terminal Illness:

Evacuation

Reasonable expenses for:

of a Specialist.

Eligible Medical Condition.

Repatriation

20. Mortal Remains:

who has travelled as an escort.

Palliative and Hospice Care: On diagnosis of a **Terminal** illness, costs for any **In-Patient**, Day-Patient or Out-Patient Treatment given on the advice of a Medical Practitioner or **Specialist** for the purpose of offering temporary relief of symptoms. Charges for Hospital or hospice accommodation, nursing care by a Qualified Nurse and prescribed Drugs and Dressings are covered.

18. Emergency Non-Elective Treatment USA Cover:

For planned trips up to 30 days of duration. **Treatment** by a **Medical Practitioner** or Specialist starting within 24 hours of the Emergency event, required as a result of an Accident or the sudden beginning of a severe illness resulting in a Medical Condition that presents an immediate threat to the Insured Person's health.

Charges relating to routine Pregnancy and Pregnancy and Childbirth Medical Conditions are specifically excluded from this Benefit.

Day-Patient care Illness: In-Patient and Day-Patient care Up to USD 25,000 per Period of Cover Out-Patient Treatment in an Accident and Emergency Department in a Hospital up to USD 500 per Period of Cover 19. Evacuation and Repatriation: Pre-Authorisation 🖀 Arrangements will be made to move an **Insured Person** who has a critical, life-threatening Eligible Medical Condition to the nearest medical facility for the purpose of admission to Hospital as an In-Patient or Day-Patient. (i) Transportation costs of an Insured Person in the event of Emergency Treatment and (i) Medically Necessary transport and care not being readily available at the plac of the incident. This includes an economy class airfare ticket for a locally-accompanying person Full refund (ii) (ii) Reasonable local travel costs to and from medical appointments when **Treatment** is being received as a Day-Patient. Full refund (iii) Reasonable travel costs for a locally-accompanying person to travel to and from the (iii) Hospital to visit the Insured Person following admission as an In-Patient. (iv) Reasonable costs for non-Hospital Accommodation only for immediate pre and Full refund post-Hospital admission periods provided that the Insured Person is under the care (iv) Costs of **Evacuation** do not extend to include any air-sea rescue or mountain rescue costs Up to USD 200 that are not incurred at recognised ski resorts or similar winter sports resorts. per day Our medical advisers will decide the most appropriate method of transportation for the Up to USD 7,500 Evacuation and this Benefit will not cover travel if it is against the advice of Our medical per person, advisers or where the medical facility does not have appropriate facilities to treat the per Evacuation An economy class airfare ticket to return the Insured Person and a locally-accompanying Pre-Authorisation @ person who has travelled as an escort to the site of Treatment or the Insured Person's principal Country of Nationality or principal Country of Residence, as long as the journey is made within one month of completion of Treatment. Charges relating to routine Pregnancy and Pregnancy and Childbirth Medical Conditions Full refund are specifically excluded from this **Benefit**. In the event of death from an Eligible Medical Condition, Reasonable and Customary Pre-Authorisation 🖀 (i) Full refund (ii) Up to USD 10,000 USD 125 per night

For this **Benefit** exclusion 5.10 does not apply.

Subject to limits Optional

Essential

Eligible In-Patient

and Day-Patient

Treatment only up to USD 50,000 lifetime limit

Accident:

Full refund for Accident requiring In-Patient and

Charges for: Costs of transportation of body or ashes of an Insured Person to his/her (i) Country of Nationality or Country of Residence, or

(ii) Burial or cremation costs at the place of death in accordance with reasonable and customary practice

21. Hospital Cash Benefit:

This Benefit is payable for each night an Insured Person receives In-Patient Treatment and only if an **Insured Person** is admitted for **In-Patient Treatment** before midnight, and the **Treatment** is received free of charge that would have otherwise been **Eligible** for **Benefit** privately under this **Plan**. Cover under this **Benefit** is limited to a maximum of 30 nights per Period of Cover.

	nefit	Essentia
22.	Out-Patient Charges: Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. Any pre-operative and post-hospitalisation consultations are payable under this Benefit.	Pre-operative consultation with 15 days from the admission and po- hospitalisation consultation with 30 days followin discharge from Hospital Up to maximum USD 2,000 per Medical Condition per Period of Con
23.	Day-Patient or Out-Patient Surgery:	
	Treatment costs for a Surgical Procedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any pre or post-operative consultations are payable under Benefit 22 – Out-Patient charges.	Full refund
24.	Out Patient Psychiatric Illness:	
	Out-Patient Treatment administered under the direct control of a Registered Psychiatrist when referred by a Medical Practitioner or Specialist .	
	This Benefit includes Treatment administered by a Psychologist subject to 10 sessions and the cost limit under this section.	Not covered
25.	Out-Patient Physiotherapy and Alternative Therapies:	
	(i) Physiotherapy by a Registered Physiotherapist , when referred by a Medical Practitioner , or Specialist .	(i)
	 (ii) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). 	Up to 5 session within 30 days af hospitalisation.
	(iii) Out-Patient Treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner.	Not covered
	We do not cover charges for general chiropody or podiatry. For this Benefit the Plan Out-Patient Per Visit Excess does not apply.	(iii) Not covered
26.	Nursing Care at Home:	Pre-Authorisation
	(i) Care given by Qualified Nurse in the Insured Person's own home, which is immediately received subsequent to Treatment as an In-Patient or Day-Patient on the recommendation of a Medical Practitioner or Specialist.	(i) Up to USD 100 per day, up to 30 days pe Medical Condition
	(ii) Emergency Medical Practitioner (GP) home visits out of normal clinic hours.	(ii) Not covered
27.	AIDS:	
	 Medical expenses, which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. As result of proven occupation Accident* or blood transfusion**. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, Drugs and Dressings (except experimental or those unproven), Hospital Accommodation and nursing fees. * For members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation; and they contracted the HIV infection three years after the Entry Date or Start Date, whichever is later; and the incident from which they contracted the HIV infection was reported, investigated and documented according to normal procedures for the Insured Person's occupation; and a test showing no HIV or antibodies to such a virus was made within five days of the incident. ** As long as the blood transfusion was received as an In-Patient as part of Medically Neccessary Treatment. Waiting Period: Cover only available after three years of continuous membership. 	Pre-Authorisation Eligible In-Patie and Day-Patien Treatment only up to USD 25,00 per Period of Con

Options to Core Benefits

28. USA Elective Treatment:

- (i) Costs associated with Eligible In-Patient and Day-Patient Treatment in the USA will be paid in full where Treatment is received in a Hospital listed in the Now Health International Provider Network.
- (ii) Costs associated with Eligible Out-Patient Treatment in the USA will be paid in full where Treatment is received in the Now Health International Provider Network.

Treatment that is not received in the Now Health International Provider Network will be subject to a 50% Co-Insurance.

29. Out-Patient Charges:

- Medical Practitioner fees including consultation, Specialist fees, Diagnostic Tests, prescribed Drugs and Dressings.
- a. Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist.
 - b. Complementary medicine and **Treatment** by a therapist, when referred by a **Medical Practitioner** or **Specialist**. This **Benefit** extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture **Treatment** but excludes **Physiotherapist** covered in (i).
 - c. **Out-Patient Treatment** for therapies administered by a recognised traditional Chinese **Medical Practitioner** or an Ayurvedic **Medical Practitioner**.

We do not cover charges for general chiropody or podiatry.

For this Benefit the Plan Out-Patient Per Visit Excess does not apply.

Any pre-operative and post-hospitalisation consultations are payable under this **Benefit**. This **Benefit** replaces **Benefit** 22 – **Out-Patient** Charges.

Please note that if this option is chosen, the only **Plan Deductible** options that

can be chosen are USD 1,000, USD 2,500 or USD 5,000.

If **You** choose an optional **Deductible**, **You** must also select a **Co-Insurance Out-Patient Treatment** option

30. Out-Patient Charges Option 2:

- Medical Practitioner fees including consultation, Specialist fees, Diagnostic Tests and costs associated with maintenance of chronic Medical Conditions, prescribed Drugs and Dressings.
- (ii) a. Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist.
 - b. Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i).
 - c. **Out-Patient Treatment** for therapies administered by a recognised traditional Chinese **Medical Practitioner** or an Ayurvedic **Medical Practitioner**.

We do not cover charges for general chiropody or podiatry.

For this Benefit the Plan Out-Patient Per Visit Excess does not apply.

Any pre-operative and post-hospitalisation consultations are payable under this **Benefit**. This **Benefit** replaces **Benefit** 22 – **Out-Patient** Charges.

Please note that if this option is chosen, the only **Plan Deductible** options that can be chosen are USD 1,000, USD 2,500 or USD 5,000.

If You choose an optional **Deductible**, You must also select a **Co-Insurance Out-Patient** Treatment option.

31. Co-Insurance Out-Patient Treatment:

A 10% **Co-Insurance** will apply to all **Eligible Out-Patient Treatment**. Should **Your Plan** include the Maternity, Dental care or Wellness, Optical and **Vaccinations Benefits**, any applicable **Co-Insurance** will be detailed in **Your Benefit Schedule**. Please note that the **Co-Insurance** will not apply to **Treatment** relating to Renal dialysis/ Renal failure, **Cancer** or Organ Transplants.

32. Co-Insurance Out-Patient Treatment Option 2:

A 20% **Co-Insurance** will apply to all **Eligible Out-Patient Treatment**. Should **Your Plan** include the Maternity, Dental care or Wellness, Optical and **Vaccinations Benefits**, any applicable **Co-Insurance** will be detailed in **Your Benefit Schedule**. Please note that the **Co-Insurance** will not apply to **Treatment** relating to Renal dialysis/

Renal failure, **Cancer** or Organ Transplants.

Essential

Pre-Authorisation for Out-Patient diagnostics and surgery, Day-Patient and In-Patient Treatment 🖀

Optional Up to USD 1.5m per **Insured Person** per **Period of Cover**

Optional

Up to USD 4,500 per **Period of Cover**

(i)

(ii)

Full refund up to a maximum 10 sessions per **Period of Cover** in aggregate. Physiotherapy is limited to 10 sessions and not in addition to **Benefit** 25.

(i) Optional Up to USD 4,500 per **Period of Cover**

Full refund

(ii)

up to a maximum 10 sessions per **Period of Cover** in aggregate. Physiotherapy is limited to 10 sessions and not in addition to **Benefit** 25.

Optional

Optional

ptions to Core Benefits	Essential	
 Extended Evacuation and Repatriation: Evacuation Arrangements will be made to move an Insured Person who has a critical, life-threatening Eligible Medical Condition to the nearest medical facility, Country of Residence, Country of Nationality or the Insured Member's country of choice for the purpose of admission to Hospital as an In-Patient or Day-Patient. Reasonable expenses for: (i) Transportation costs of an Insured Person in the event of Emergency Treatment and Medically Necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying person who has travelled as an escort. (ii) Reasonable local travel costs to and from medical appointments when Treatment is being received as a Day-Patient. (iii) Reasonable locast for a locally-accompanying person to travel to and from the Hospital to visit the Insured Person following admission as an In-Patient. (iv) Reasonable costs for non-Hospital Accommodation only for immediate pre and post-Hospital admission periods provided that the Insured Person is under the care of a Specialist. 	Pre-Authorisation	
Costs of Evacuation do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts. The Insured Member's country of choice is subject to the availability of the appropriate medical facilities being in place. Our medical advisers will determine whether the selected country has the suitable medical facility to treat the Insured Member's Eligible Medical Condition . Our medical advisers will decide the most appropriate method of transportation for the Evacuation and this Benefit will not cover travel if it is against the advice of Our medical advisers or where the medical facility does not have appropriate facilities to treat the Eligible Medical Condition .	Up to USD 200 per day Up to USD 7,50 per person, per Evacuatio	
Repatriation An economy class airfare ticket to return the Insured Person and a locally-accompanying person who has travelled as an escort to the site of Treatment or the Insured Person's principal Country of Nationality or principal Country of Residence , as long as the journey is made within one month of completion of Treatment . Reasonable cost of the above will be paid in full. Charges relating to routine Pregnancy and Pregnancy and Childbirth Medical Conditions are specifically excluded from this Benefit .	Pre-Authorisation T	

Deductible Options

Standard Deductible	Nil
Optional Deductible: Please note: Deductibles would apply to any Medically Necessary Treatment required under Benefit 19 and Benefit 33.	USD 1,000 USD 2,500 USD 5,000 USD 10,000 USD 15,000

WorldCare Essential is not available to Insured Persons with residence visas in the Emirate of Abu Dhabi.

Essential

4.3.2 WorldCare Advance

Annual Maximum Plan Limit 24/7 helpline and assistance services available on all Plans	
	USD 3.5m
1. Maintenance of Chronic Medical Conditions: Maintenance of chronic Medical Conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, examinations, check-ups, Drugs and Dressings and/or tests up to the Benefit limits following Your Entry Date. This Benefit does not cover renal failure and dialysis. Claims for this will fall under Benefit 6. Claims for Cancer will fall under Benefit 8.	Full refund
 Hospital Charges, Medical Practitioner and Specialist Fees: Charges for In-Patient or Day-Patient Treatment made by a Hospital including charge for accommodation (ward/semi-private or private); Diagnostic Tests; operating theatric charges including surgeon and anaesthetist charges; and charges for nursing care by a Qualified Nurse; Drugs and Dressings prescribed by a Medical Practitioner or Specialist; and surgical appliances used by the Medical Practitioner during surgery. Trincludes pre and post-operative consultations while an In-Patient or Day-Patient and includes charges for intensive care. Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propell non-electronic wheelchairs within six months of an Eligible Medical Condition which required In-Patient or Day-Patient Hospital Treatment. 	e (// Full refund This Pre-Authorisation (for (i) C
3. Diagnostic Procedures: Medically Necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an In-Patient, Day-Patient or Out-Patient.	Pre-Authorisation for PET 🖀 Full refund
 Emergency Ambulance Transportation: Emergency road ambulance transport costs to or between Hospitals, or when considere Medically Necessary by a Medical Practitioner or Specialist. 	ed Full refund
5. Parent Accommodation: The cost of one parent staying in Hospital overnight with an Insured Person under 18 ye old while the child is admitted as an In-Patient for Eligible Treatment.	ears Full refund
 6. Renal Failure and Renal Dialysis: (i) Treatment of renal failure, including renal dialysis on an In-Patient basis. (ii) Treatment of renal failure, including renal dialysis on a Day-Patient or Out-Patient basis. 	(i) Full refund asis. (ii) Up to USD 100,000 per Period of Cover
 7. Organ Transplant: (i) Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the Insured Person as a recipient. In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Benefit 12 but excluded from Benefit 7 – Organ Transplant. (ii) Medical costs associated with the donor as an In-Patient or Day-Patient, with the exception of the cost of the donor organ search. We only pay for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines. 	(i) Full refund (ii) Up to USD 50,000 per Period of Cover
 Cancer Treatment: Treatment given for Cancer received as an In-Patient, Day-Patient or Out-Patient. Includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combinatio from the point of diagnosis. 	on, Full refund

ье	nefit	Advance
9.	 Pregnancy and Childbirth Medical Conditions: In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. As an illustration, We would consider Treatment of the following: Ectopic Pregnancy (where the foetus is growing outside the womb) Hydatidiform mole (abnormal cell growth in the womb) Retained placenta (afterbirth retained in the womb) Placenta praevia Eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia) Diabetes (If You have exclusions because of Your past medical history which relate to diabetes, then You will not be covered for any Treatment for diabetes during Pregnancy) Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth) Miscarriage requiring immediate surgical Treatment Failure to progress in labour 	Full refund
10.	New Born Cover: In-Patient Treatment of premature birth (i.e. prior to age 37 weeks gestation) or an Acute Condition being suffered by a New Born baby of an Insured Person which manifests itself within 30 days following birth. Provided that the New Born baby is added to the Plan within 30 days of birth and premium paid. Cover for multiple births will be covered up to the same limits shown. In circumstances where We require details of the New Born baby's medical history before the baby is being added to the Plan, We reserve the right to apply particular restrictions to the cover We will offer. Please refer to Section 6.5 - Adding New Born of this Members' Handbook for details.	Up to USD 100,00 per Period of Cov
11.	Hospital Accommodation for New Born Accompanying their Mother: Hospital Accommodation costs relating to a New Born baby (up to 16 weeks old) to accompany its mother (being an Insured Person) while she is receiving Eligible Treatment as an In-Patient in a Hospital.	Full refund
12.	Congenital Disorder: In-Patient Treatment for a Congenital Disorder. In circumstances where a Congenital Disorder manifests itself in a New Born baby within 30 days of birth, cover for such Medical Conditions will be provided under Benefit 10 but excluded from Benefit 12 – Congenital Disorders.	Up to USD 100,00 per Period of Cov
13.	Reconstructive Surgery: Reconstructive surgery required to restore natural function or appearance following an Accident or following a Surgical Procedure for an Eligible Medical Condition , which occurred after an Insured Person's Entry Date or Start Date whichever is later.	Full refund
14.	Rehabilitation: When referred by a Specialist as an integral part of Treatment for a Medical Condition necessitating admission to a recognised Rehabilitation unit of a Hospital. Where the Insured Person was confined to a Hospital as an In-Patient for at least three consecutive days, and where a Specialist confirms in writing that Rehabilitation is required. Admission to a Rehabilitation unit must be made within 14 days of discharge from Hospital. Such Treatment should be under the direct supervision and control of a Specialist and would cover: (i) Use of special Treatment rooms (ii) Physical therapy fees (iii) Speech therapy fees (iv) Occupational therapy fees	Full refund up to 180 days pe Medical Conditio
T	 In-Patient Emergency Dental Treatment: This means Emergency restorative dental Treatment required to sound, natural teeth following an Accident which necessitates Your admission to Hospital for at least one night. The dental Treatment must be received within 10 days of the Accident. This Benefit covers all costs incurred for Treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply: If the Treatment involves replacing a crown, bridge facing, veneer or denture, We will pay only the reasonable and customary cost of a replacement of similar type or quality If implants are clinically needed We will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead This Benefit also covers repair or reconstruction of dentures broken following an Accident hat necessitates the Insured Person's admission to a Hospital for at least one night, provided hat such dentures were being worn at the time of the Accident. 	Full refund
16.	In-Patient Psychiatric Treatment: In-Patient Treatment in a recognised Psychiatric unit of a Hospital. All Treatment must be administered under the direct control of a Registered Psychiatrist.	Pre-Authorisation

Not covered > Subject to limits

Optional

Full refund

Benefit

17. Terminal Illness:

Palliative and Hospice Care: On diagnosis of a Terminal illness, costs for any In-Patient, Day-Patient or Out-Patient Treatment given on the advice of a Medical Practitioner or Specialist for the purpose of offering temporary relief of symptoms. Charges for Hospital or hospice accommodation, nursing care by a Qualified Nurse and prescribed Drugs and Dressings are covered.

18. Emergency Non-Elective Treatment USA Cover:

19. Evacuation and Repatriation:

Hospital as an In-Patient or Day-Patient.

who has travelled as an escort.

being received as a Day-Patient.

Evacuation

Reasonable expenses for:

of a Specialist.

For planned trips up to 30 days of duration **Treatment** by a **Medical Practitioner** or Specialist starting within 24 hours of the Emergency event, required as a result of an Accident or the sudden beginning of a severe illness resulting in a Medical Condition that presents an immediate threat to the Insured Person's health.

Charges relating to routine Pregnancy and Pregnancy and Childbirth Medical Conditions are specifically excluded from this **Benefit**.



20. Mortal Remains:

Repatriation

In the event of death from an Eligible Medical Condition, Reasonable and Customary Charges for:

Hospital to visit the Insured Person following admission as an In-Patient. (iv) Reasonable costs for non-Hospital Accommodation only for immediate pre and

Our medical advisers will decide the most appropriate method of transportation for the

advisers or where the medical facility does not have appropriate facilities to treat the *Eligible Medical Condition*.

that are not incurred at recognised ski resorts or similar winter sports resorts.

is made within one month of completion of Treatment.

- Costs of transportation of body or ashes of an Insured Person to his/her Country of (i) Nationality or Country of Residence or,
- (ii) Burial or cremation costs at the place of death in accordance with reasonable and customary practice

Pre-Authorisation 🖀

(i) Þ Full refund (ii)

Up to USD 10,000

Subject to limits

	enefit	Advanc
21.	Hospital Cash Benefit: This Benefit is payable for each night an Insured Person receives In-Patient Treatment and only if an Insured Person is admitted for In-Patient Treatment before midnight, and the Treatment is received free of charge that would have otherwise been Eligible for Benefit privately under this Plan. Cover under this Benefit is limited to a maximum of 30 nights per Period of Cover. For this Benefit exclusion 5.10 does not apply.	VSD 175 per n
22.	Out-Patient Charges: Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. Any pre-operative and post-hospitalisation consultations are payable under this Benefit.	Full refund
23.	Day-Patient or Out-Patient Surgery: Treatment costs for a Surgical Procedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any pre or post-operative consultations are payable under Benefit 22 – Out-Patient charges.	Full refund
24.	Out-Patient Psychiatric Illness: Out-Patient Treatment administered under the direct control of a Registered Psychiatrist when referred by a Medical Practitioner or Specialist. This Benefit includes Treatment administered by a Psychologist subject to 10 sessions and the cost limit under this section.	Up to USD 2,5 per and subject maximum o 10 sessions per Period of C
25.	 Out-Patient Physiotherapy and Alternative Therapies: (i) Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist. (ii) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). (iii) Out-Patient Treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. We do not cover charges for general chiropody or podiatry. For this Benefit the Plan Out-Patient Per Visit Excess does not apply. 	(i) Full refund up to a maxim 30 sessions per Period of C (ii) and (iii) Full refund up to a maxim of 30 visits per Period of C Pre-Authorisa for (i), (ii) and after every 10
26.	 Nursing Care at Home: (i) Care given by Qualified Nurse in the Insured Person's own home, which is immediately received subsequent to Treatment as an In-Patient or Day-Patient on the recommendation of a Medical Practitioner or Specialist. (ii) Medical Practitioner (GP) home visits for an Emergency GP home call-out during out of normal clinic hours. 	(i) Full refund up to 45 days Medical Condi Pre-Authorisa for (i) ☎ (ii) Not coverei
27.	AIDS:	
27.	 Medical expenses, which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. As result of proven occupation Accident* or blood transfusion**. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, Drugs and Dressings (except experimental or those unproven), Hospital Accommodation and nursing fees. * For members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation, and they contracted the HIV infection three years after the Entry Date or Start Date, whichever is later; and the incident from which they contracted the HIV infection was reported, investigated and documented according to normal procedures for the Insured Person's occupation; and a test showing no HIV or antibodies to such a virus was made within five days of the incident; and a positive HIV test occurred within 12 months of the reported occupational Accident. 	Pre-Authorisation
	** As long as the blood transfusion was received as an In-Patient as part of Medically	

Benefit

Advance

28. Dubai Health Authority (DHA) Mandatory requirements Benefit:

This **Plan** provides coverage up to USD 41,000 in aggregate per **Insured Person**, per **Period of Cover** for the following basic health services inclusive of **Emergency** services within the United Arab Emirates:

- (i) Pre-existing Conditions including maintenance of Chronic Medical Conditions
- (ii) Examinations, diagnostic and Treatment services (including cost of medicine) received in clinics and health centers that are provided by general Medical Practitioners and Specialists. Follow up visits are exempted from fees if made within a week from the date of the first examination.
- (iii) Laboratory tests, X-ray diagnostic services, diagnostic procedures including MRI, CT scans and endoscopies.
- (iv) Out-Patient physiotherapy Maximum 10 sessions per year.
- (v) The costs of accommodation of an accompanying person as an In-Patient in the same room in cases that are Medically Necessary at the recommendation of the Medical Practitioner or Specialist. Subject to Pre-Authorisation and up to a maximum of USD 28 per night.
- (vi) Essential Vaccinations and inoculations for newborns and children as stipulated in the DHA policies and its updates, in assigned facilities.
- (vii) Adult Pneumococcal Conjugate Vaccine as per DHA Adult Pneumococcal Vaccination guidelines.
- (viii) Preventive screening for diabetes and other screening as stipulated by the DHA every three years for **Insured Persons** above the age of 30 and every year for 18 years and above for **Insured Persons** considered high risk.
- (ix) Medically Necessary costs incurred during normal Pregnancy and childbirth, including the delivery costs, pre and post natal check-ups. Cover includes examinations, diagnostic and Treatment, and follow up visits for Pregnancy and gynecology services provided by general Medical Practitioners and Specialists (subject to referral by the general Medical Practitioner) and received in authorised health centers and clinics.
 - Cover is provided for eight visits to a Primary Healthcare (PHC) obstetrician for low risk patients or Specialist
 obstetrician for high risk patients referrals.
 - Visits to include reviews, checks and tests in accordance with DHA Antenatal Care Protocols. Initial i nvestigations to include: FBC and platelets, blood group, rhesus status and antibodies, VDRL, MSU, urinalysis, rubella serology, HIV, FBS, randoms or A1C and for high risk patients GTT and Hepatitis C.
 - The cost of three antenatal ultrasound scans.
 - In-Patient maternity is limited to a maximum of USD 1,950 for normal Pregnancy and USD 2,750 for C-section per Insured Person, per Period of Cover.
- (x) Cover is provided for a New Born baby of an Insured Person for a period of 30 days from birth within the existing aggregate limit of the Mother. This includes BCG, Hepatitis B and neo-natal screening tests (Phenylketonuria (PKU), Congenital Hypothyroidism, sickle cell screening, congenital adrenal hyperplasia).

Unless otherwise indicated these **Benefits** will not be payable for **Treatment** outside the United Arab Emirates.

No maternity Waiting Period applies on the Dubai Health Authority (DHA) Mandatory requirements Benefit.

For maternity **Benefit** outside the United Arab Emirates, the optional maternity **Benefit** must be selected or the Apex **Plan** chosen.

BASMAH Initiative:

Dubai Health Authority (DHA), as part of UAE 2021 vision and in alignment with Dubai Standards of Care has launched a **Cancer** Patient Support Program (Cancer PSP) and a **Hepatitis C** Patient Support Program (HCV PSP).

Screening, healthcare services, investigations and **Treatments** related to and associated complications related to **Cancer** shall be extended to the fund ONLY for members enrolled under the Patient Support Program (PSP) as per terms and conditions of the Program.

Screening, healthcare services, investigations and **Treatments** related to viral hepatitis and associated complications related to **Hepatitis C** shall be available ONLY for members enrolled under the Patient Support Program (PSP) as per terms and conditions of the Program.

29. Health Authority Abu Dhabi (HAAD) Mandatory requirements Benefit:

For **Insured Persons** with residence visas in the Emirate of Abu Dhabi this **Plan** is extended to provide coverage up to USD 69,000 in aggregate per **Insured Person**, per **Period of Cover** for the following basic health services within the Emirate of Abu Dhabi and for **Emergency** services within the United Arab Emirates:

- (i) Pre-existing Conditions including Maintenance of Chronic Medical Conditions.
- Medically Necessary costs incurred during normal Pregnancy and childbirth, including pre and post natal check-ups up to the Benefit limit subject to Pre-Authorisation.
- (iii) The costs of accommodation of an accompanying person as an In-Patient in the same room in cases that are Medically Necessary at the recommendation of the Medical Practitioner or Specialist. Subject to Pre-Authorisation and up to a maximum of USD 28 per night.
- (iv) Physiotherapy by a registered Physiotherapist when referred by a Medical Practitioner or a Specialist subject to Pre-Authorisation.
- (v) Hearing and vision aids and vision corrected by surgeries where Medically Necessary and as a result of an Emergency.

Unless otherwise indicated these **Benefits** will not be payable for **Treatment** outside the United Arab Emirates.

For maternity **Benefit** outside of the United Arab Emirates, the optional maternity **Benefit** must be selected. Healthcare services are covered in full for work illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulations of Work Relations, as amended and applicable laws in this respect.

Subject to limits

Opti	ions to Core Benefits	Advance
(i) (ii) Tra	 SA Elective Treatment: Costs associated with Eligible In-Patient and Day-Patient Treatment in the USA will be paid in full where Treatment is received in a Hospital listed in the Now Health International Provider Network. Costs associated with Eligible Out-Patient Treatment in the USA will be paid in full where Treatment is received in the Now Health International Provider Network. eatment that is not received in the Now Health International Provider Network will be bject to a 50% Co-Insurance. 	Pre-Authorisation for Out-Patient diagnostics and surgery, Day-Patient and In-Patient Treatment Treatment Optional Up to USD 1.5m per Insured Person per Period of Cover
(no A inc in Ple	o-Insurance Out-Patient Treatment: ot available to Insured Persons with residence visas in the Emirate of Abu Dhabi) 10% Co-Insurance will apply to all Eligible Out-Patient Treatment. Should Your Plan clude the Maternity or Dental care Benefits, any applicable Co-Insurance will be detailed Your Benefit Schedule. ease note that the Co-Insurance will not apply to Treatment relating to Renal dialysis/ enal failure, Cancer or Organ Transplants.	D ptional
(no A 2 inc in Ple	o-Insurance Out-Patient Treatment Option 2: ot available to Insured Persons with residence visas in the Emirate of Abu Dhabi) 20% Co-Insurance will apply to all Eligible Out-Patient Treatment. Should Your Plan clude the Maternity or Dental care Benefits, any applicable Co-Insurance will be detailed Your Benefit Schedule. ease note that the Co-Insurance will not apply to Treatment relating to Renal dialysis/ enal failure, Cancer or Organ Transplants.	Optional
(no (or Or Cit Ple	estricted Network – UAE Residents only: ot available to Insured Persons with residence visas in the Emirate of Abu Dhabi) nly available for new Plans in force on or after 1 August 2015) or Benefit will be payable in respect of costs associated with Eligible In-Patient, Day-Patient Out-Patient Treatment made at either the American Hospital and associated clinics, ty Hospital, Welcare Hospital and associated Hospitals and clinics of the Mediclinic Group. ease note that if You selected the USD 25 per visit Out-Patient Excess or one of the bo-Insurance Plan options, these will still apply in the Restricted Network.	Optional
(i) (ii) (iii,	 Vellness, Optical and Vaccinations: Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol) and/or Optical Benefits: This Benefit also provides a contribution towards optician charges including frames and lenses; and/or contact lenses when the member's prescription has changed, within the combined Benefit limits to a maximum USD300 per Period of Cover for an optical claim. Please note that there is no cover for prescription sunglasses or transition lenses. and/or Oxacinations: Costs of drugs and consultations to administer all Medically Necessary basic immunisation and booster injections and any Medically Necessary travel Vaccinations and malaria prophylaxis. or this Benefit exclusion 5.10 does not apply. Wating Period: Cover only available after six months of continuous membership. 	Optional Combined limit Up to USD 500 per Period of Cover
(i) (ii)	 Vellness, Optical and Vaccinations Option 2: Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol) and/or Optical Benefits: This Benefit also provides a contribution towards optician charges including an annual eye test carried out by an Opthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, within the combined Benefit limits to a maximum USD600 per Period of Cover for an optical claim. Please note that there is no cover for prescription sunglasses or transition lenses. and/or Vaccinations: Costs of drugs and consultations to administer all Medically Necessary basic immunisation and booster injections and any Medically Necessary travel Vaccinations and malaria prophylaxis. 	Optional Combined limit Up to USD 1,000 per Period of Cover

Full refund

Not covered > Subject to limits

Optional

Options to Core Benefits

36. Extended Evacuation and Repatriation:

Evacuation

Arrangements will be made to move an **Insured Person** who has a critical, life-threatening **Eligible Medical Condition** to the nearest medical facility, **Country of Residence**, **Country of Nationality** or the Insured Member's country of choice for the purpose of admission to **Hospital** as an **In-Patient** or **Day-Patient**.

Reasonable expenses for:

- (i) Transportation costs of an Insured Person in the event of Emergency Treatment and Medically Necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying person who has travelled as an escort.
- (ii) Reasonable local travel costs to and from medical appointments when Treatment is being received as a Day-Patient.
- (iii) Reasonable travel costs for a locally-accompanying person to travel to and from the Hospital to visit the Insured Person following admission as an In-Patient.
- (iv) Reasonable costs for non-Hospital Accommodation only for immediate pre and post-Hospital admission periods provided that the Insured Person is under the care of a Specialist.

Costs of **Evacuation** do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts.

The Insured Member's country of choice is subject to the availability of the appropriate medical facilities being in place. **Our** medical advisers will determine whether the selected country has the suitable medical facility to treat the Insured Member's **Eligible Medical Condition**. **Our** medical advisers will decide the most appropriate method of transportation for the **Evacuation** and this **Benefit** will not cover travel if it is against the advice of **Our** medical advisers or where the medical facility does not have appropriate facilities to treat the **Eligible Medical Condition**.

Repatriation

An economy class airfare ticket to return the **Insured Person** and a locally-accompanying person who has travelled as an escort to the site of **Treatment** or the **Insured Person's** principal **Country of Nationality** or principal **Country of Residence**, as long as the journey is made within one month of completion of **Treatment**. Reasonable cost of the above will be paid in full.

Charges relating to routine **Pregnancy** and **Pregnancy and Childbirth Medical Conditions** are specifically excluded from this **Benefit**.

Out-Patient Per Visit Excess Options

Out-Patient Per Visit Excess:

Out-Patient Per visit excess:	
A USD 25 Out-Patient Per Visit Excess will apply when You receive Eligible Out-Patient Treatment inside and outside of the Now Health International Provider Network.	•
Please note:	Optional
The Out-Patient Per Visit Excess does not apply to the Alternative Therapies Benefits . If Your Plan also includes Dental care Benefit , as detailed in Your Benefit Schedule , no Out-Patient Per Visit Excess will be applicable.	USD 25
Out-Patient Per Visit Excess – Option 2:	
A USD 15 Out-Patient Per Visit Excess will apply when You receive Eligible Out-Patient	
Treatment inside and outside the Now Health International Provider Network.	A 11 1
Treatment inside and outside the Now Health International Provider Network. Please note:	Optional

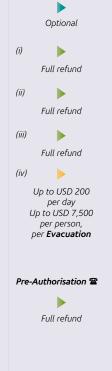
Out-Patient Per Visit Excess options – Please note that only option 2 is available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

Deductible Options

Standard Deductible Nil Optional Deductible: USD 1,000 Please note: USD 2,500 If You choose an optional Deductible, You must also select either a Co-Insurance Out-Patient USD 2,500 If You choose an optional Deductible, You must also select either a Co-Insurance Out-Patient USD 5,000 Treatment Option or a Out-Patient Per Visit Excess Option. USD 10,000 Deductibles would apply to any Medically Necessary Treatment required under USD 15,000

Please note Deductibles are not available to Insured Persons with residence visas in the Emirates of Dubai or Abu Dhabi.

Pre-Authorisation 🖀



Advance

Advance

4.3.3 WorldCare Excel

Be	enefit	Excel	
Annual Maximum Plan Limit 24/7 helpline and assistance services available on all Plans		USD 4m	
1.	Maintenance of Chronic Medical Conditions: Maintenance of chronic Medical Conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, examinations, check-ups, Drugs and Dressings and/or tests up to the Benefit limits detailed following Your Entry Date. This Benefit does not cover renal failure and dialysis. Claims for this will fall under Benefit 6. Claims for Cancer will fall under Benefit 8.	Full refund	
2.	 Hospital Charges, Medical Practitioner and Specialist Fees: (i) Charges for In-Patient or Day-Patient Treatment made by a Hospital including charges for accommodation (ward/semi-private or private); Diagnostic Tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a Qualified Nurse; Drugs and Dressings prescribed by a Medical Practitioner or Specialist; and surgical appliances used by the Medical Practitioner or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes charges: Purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an Eligible Medical Condition which required In-Patient or Day-Patient Hospital Treatment. 	 (i) Full refund Pre-Authorisation for (i) ≅ (ii) ↓ Up to USD 2,000 pe Medical Condition 	
3.	Diagnostic Procedures: Medically Necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an In-Patient, Day-Patient or Out-Patient.	Pre-Authorisation for PET T	
4.	Emergency Ambulance Transportation: Emergency road ambulance transport costs to or between Hospitals, or when considered Medically Necessary by a Medical Practitioner or Specialist.	Full refund	
5.	Parent Accommodation: The cost of one parent staying in Hospital overnight with an Insured Person under 18 years old while the child is admitted as an In-Patient for Eligible Treatment.	Full refund	
6.	Renal Failure and Renal Dialysis: (<i>i</i>) Treatment of renal failure, including renal dialysis on an In-Patient basis. (<i>ii</i>) Treatment of renal failure, including renal dialysis on a Day-Patient or Out-Patient basis.	(i) Full refund (ii) Up to USD 100,000 core Decided Core	
7.	 Organ Transplant: (i) Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the Insured Person as a recipient. In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Benefit 12 but excluded from Benefit 7 – Organ Transplant. (ii) Medical costs associated with the donor as an In-Patient or Day-Patient, with the exception of the cost of the donor organ search. We only pay for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines. 	(i) Full refund (ii) Up to USD 50,000 per Period of Cove	
8.	Cancer Treatment: Treatment given for Cancer received as an In-Patient, Day-Patient or Out-Patient. Includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis.	Full refund	

Benefit	Excel
 9. Pregnancy and Childbirth Medical Conditions: In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. As an illustration, We would consider Treatment of the following: Ectopic Pregnancy (where the foetus is growing outside the womb): Hydatidiform mole (abnormal cell growth in the womb) Retained placenta (afterbirth retained in the womb) Placenta praevia Eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia) Diabetes (If You have exclusions because of Your past medical history which relate to diabetes, then You will not be covered for any Treatment for diabetes during Pregnancy) Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth) Miscarriage requiring immediate surgical Treatment 	F ull refund
 10. New Born Cover: In-Patient Treatment of premature birth (i.e. prior to age 37 weeks gestation) or an Acute Condition being suffered by a New Born baby of an Insured Person which manifests itself within 30 days following birth. Provided that the New Born baby is added to the Plan within 30 days of birth and premium paid. Cover for multiple births will be covered up to the same limits shown. In circumstances where We require details of the New Born baby's medical history before the baby is being added to the Plan, We reserve the right to apply particular restrictions to the cover We will offer. Please refer to Section 6.5 - Adding New Born of this Members' Handbook for details. 	► Up to USD 125,000 per Period of Cove
11. Hospital Accommodation for New Born Accompanying their Mother: Hospital Accommodation costs relating to a New Born baby (up to 16 weeks old) to accompany its mother (being an Insured Person) while she is receiving Eligible Treatment as an In-Patient in a Hospital.	Full refund
12. Congenital Disorder: In-Patient Treatment for a Congenital Disorder. In circumstances where a Congenital Disorder manifests itself in a New Born baby within 30 days of birth, cover for such Medical Conditions will be provided under Benefit 10 but excluded from Benefit 12 – Congenital Disorders.	Up to USD 125,000 per Period of Cove
13. Reconstructive Surgery: Reconstructive surgery required to restore natural function or appearance following an Accident or following a Surgical Procedure for an Eligible Medical Condition , which occurred after an Insured Person's Entry Date or Start Date whichever is later.	Full refund
 14. Rehabilitation: When referred by a Specialist as an integral part of Treatment for a Medical Condition necessitating admission to a recognised Rehabilitation unit of a Hospital. Where the Insured Person was confined to a Hospital as an In-Patient for at least three consecutive days, and where a Specialist confirms in writing that Rehabilitation is required. Admission to a Rehabilitation unit must be made within 14 days of discharge from Hospital. Such Treatment should be under the direct supervision and control of a Specialist and would cover: (i) Use of special Treatment rooms (ii) Physical therapy fees (iii) Speech therapy fees (iv) Occupational therapy fees 	Full refund
 15. In-Patient Emergency Dental Treatment: This means Emergency restorative dental Treatment required to sound, natural teeth following an Accident which necessitates Your admission to Hospital for at least one night. The dental Treatment must be received within 10 days of the Accident. This Benefit covers all costs incurred for Treatment made necessary by an accidental injury caused by an extra- oral impact, when the following conditions apply: If the Treatment involves replacing a crown, bridge facing, veneer or denture, We will pay only the reasonable and customary cost of a replacement of similar type or quality If implants are clinically needed We will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead This Benefit also covers repair or reconstruction of dentures broken following an Accident that necessitates the Insured Person's admission to a Hospital for at least one night, provided that such dentures were being worn at the time of the Accident. 	► Full refund
16. In-Patient Psychiatric Treatment: In-Patient Treatment in a recognised Psychiatric unit of a Hospital. All Treatment must be administered under the direct control of a Registered Psychiatrist.	Pre-Authorisation 1 Full refund limited to 30 days per Period of Cover

Be	enefit	Excel
17.	Terminal Illness: Palliative and Hospice Care: On diagnosis of a Terminal illness, costs for any In-Patient , Day-Patient or Out-Patient Treatment given on the advice of a Medical Practitioner or Specialist for the purpose of offering temporary relief of symptoms. Charges for Hospital or hospice accommodation, nursing care by a Qualified Nurse and prescribed Drugs and Dressings are covered.	Up to USD 75,000 lifetime limit
18	Emergency Non-Elective Treatment USA Cover: For planned trips up to 30 days of duration. Treatment by a Medical Practitioner or Specialist starting within 24 hours of the Emergency event, required as a result of an Accident or the sudden beginning of a severe illness resulting in a Medical Condition that presents an immediate threat to the Insured Person's health. Charges relating to routine Pregnancy and Pregnancy and Childbirth Medical Conditions are specifically excluded from this Benefit.	Accident: Full refund for Accident requiring In-Patient and Day-Patient care Nullness: In-Patient and Day-Patient care up to USD 35,000 per Period of Cove Out-Patient Treatment in an Accident and Emergency Department in a Hospital up to USD 500 per Period of Cove
19	 Evacuation and Repatriation: Evacuation Arrangements will be made to move an Insured Person who has a critical, life-threatening Eligible Medical Condition to the nearest medical facility for the purpose of admission to Hospital as an In-Patient or Day-Patient. Reasonable expenses for: (i) Transportation costs of an Insured Person in the event of Emergency Treatment and Medically Necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying person who has travelled as an escort. (ii) Reasonable local travel costs to and from medical appointments when Treatment is being received as a Day-Patient. (iii) Reasonable travel costs for a locally-accompanying person to travel to and from the Hospital to visit the Insured Person following admission as an In-Patient. (iv) Reasonable costs for non-Hospital Accommodation only for immediate pre and post-Hospital admission periods provided that the Insured Person is under the care of a Specialist. Costs of Evacuation do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts. Our medical dovisers will decide the most appropriate method of transportation for the Evacuation and this Benefit will not cover travel if it is against the advice of Our medical advisers or where the medical facility does not have appropriate facilities to treat the Eligible Medical Condition. Meconomy class airfare ticket to return the Insured Person and a locally-accompanying person who has travelled as an escort to the site of Treatment or the Insured Person's principal Country of Nationality or principal Country of Residence, as long as the journey is made within one month of completion of Treatment. 	Pre-Authorisation
20	Mortal Remains: In the event of death from an Eligible Medical Condition, Reasonable and Customary Charges for: (i) Costs of transportation of body or ashes of an Insured Person to his/her Country of Nationality or Country of Residence or,	Pre-Authorisation

▶ Full refund ▶ Not covered ▶ Subject to limits

Optional

50	nefit	Excel
21.	Hospital Cash Benefit: This Benefit is payable for each night an Insured Person receives In-Patient Treatment and only if an Insured Person is admitted for In-Patient Treatment before midnight, and the Treatment is received free of charge that would have otherwise been Eligible for Benefit privately under this Plan. Cover under this Benefit is limited to a maximum of 30 nights per Period of Cover. For this Benefit exclusion 5.10 does not apply.	VSD 225 per ni
22.	Out-Patient Charges: Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. Any pre-operative and post-hospitalisation consultationns are payable under this Benefit.	Full refund
23.	Day-Patient or Out-Patient Surgery: Treatment costs for a Surgical Procedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any pre or post-operative consultations are payable under Benefit 22 – Out-Patient charges.	Full refund
24.	Out Patient Psychiatric Illness: Out-Patient Treatment administered under the direct control of a Registered Psychiatrist when referred by a Medical Practitioner or Specialist. This Benefit includes Treatment administered by a Psychologist subject to 10 sessions and the cost limit under this section.	Up to USD 5,0 and subject to maximum ol 10 sessions per Period of Co
25.	 Out-Patient Physiotherapy and Alternative Therapies: (i) Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist. (ii) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). (iii) Out-Patient Treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. We do not cover charges for general chiropody or podiatry. For this Benefit the Plan Out-Patient Per Visit Excess does not apply. 	(i) Full refund (ii) and (iii) Full refund Pre-Authorisat for (i), (ii) and (after every 10 sessions 1
26.	Nursing Care at Home:	
	 (i) Care given by Qualified Nurse in the Insured Person's own home, which is immediately received subsequent to Treatment as an In-Patient or Day-Patient on the recommendation of a Medical Practitioner or Specialist. (ii) Medical Practitioner (GP) home visits for an Emergency GP home call-out during out of normal clinic hours. 	(i) Full refund up to 60 days J Medical Condin Pre-Authorisat for (i) (ii) Not covered
27.	AIDS:	
	 Medical expenses, which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. As result of proven occupation Accident* or blood transfusion**. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, Drugs and Dressings (except experimental or those unproven), Hospital Accommodation and nursing fees. * For members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation; and they contracted the HIV infection three years after the Entry Date or Start Date, whichever is later; and the incident from which they contracted the HIV infection; and a test showing no HIV or antibodies to such a virus was made within five days of the incident. ** As long as the blood transfusion was received as an In-Patient as part of Medically Necessary Treatment. Waiting Period: Cover only available after three years of continuous membership. 	Pre-Authorisatic

		fit	Excel
28. D)en	ital Care:	
(i)		 Routine Dental Treatment: Fees of a registered Dental Practitioner carrying out routine dental Treatment in a dental surgery. Routine dental Treatment means: Screening (twice per year), i.e. the assessment of diseased, missing and filled teeth, including x-rays where necessary, Preventive scaling, polishing, and sealing (once per year), Fillings (standard amalgam or composite fillings) and extractions, and Root-canal Treatment (but not the fitting of a crown following root-canal Treatment). No other Treatment is covered under the routine dental Treatment Benefit. 	(i) Up to USD 1,00 per Period of Ca
		Waiting Period: Costs incurred within nine months from the Start Date are excluded.	
		A Co-Insurance of 20% applies.	
		For this Benefit the Plan Deductible or Plan Out-Patient Per Visit Excess does not apply.	
(iı		Complex Dental Treatment : Fees of a registered Dental Practitioner and associated costs for the following procedures: Eligible complex dental Treatment : including for example, Apicoectomy done to treat the following – Fractured tooth root; A severely curved tooth root; Teeth with caps or posts; Cyst or infection which is untreatable with root canal therapy; Root perforations; New or repair of crowns, dentures, in lays and bridges. Recurrent pain and infection; Persistent symptoms that do not indicate problems from x-rays. Calcification; Damaged root surfaces and surrounding bone requiring surgery.	(ii) Up to USD 2,00 per Period of Cc
		No other Treatment is covered by this Benefit .	
		Waiting Period: Costs incurred within nine months from the Start Date are excluded.	
		A Co-Insurance of 20% applies.	
		A 50% Co-Insurance applies in respect of all orthodontic Treatment . For this Benefit the Plan Deductible or Plan Out-Patient Per Visit Excess does not apply.	
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		Plan provides coverage up to USD 41,000 in aggregate per Insured Person, per Period of C health services inclusive of Emergency services within the United Arab Emirates:	Cover for the followin
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ы (i) (i) (i) (i) (i) (i) (i) (i) (i) (i)	asic ;) ;i) ;ii) ;iv) vii) viii) viii) ix) x) Inle:	 health services inclusive of Emergency services within the United Arab Emirates: Pre-existing Conditions including maintenance of Chronic Medical Conditions. Examinations, diagnostic and Treatment services (including cost of medicine) received in clin that are provided by general Medical Practitioners and Specialists. Follow up visits are exemade within a week from the date of the first examination. Laboratory tests, X-ray diagnostic services, diagnostic procedures including MRI, CT scans are Out-Patient physiotherapy - Maximum 10 sessions per year. The costs of accommodation of an accompanying person as an In-Patient in the same room are Medically Necessary at the recommendation of the Medical Practitioner or Specialis Pre-Authorisation and up to a maximum of USD 28 per night. Essential Vaccinations and inoculations for newborns and children as stipulated in the DHA in assigned facilities. Adult Pneumococcal Conjugate Vaccine as per DHA Adult Pneumococcal Vaccination guide Preventive screening for diabetes and other screening as stipulated by the DHA every three Persons above the age of 30 and every year for 18 years and above for Insured Persons con Medically Necessary costs incurred during normal Pregnancy and childbirth, including the post natal check-ups. Cover includes examinations, diagnostic and Treatment, and follow up and gynecology services provided by general Medical Practitioners and Specialists (subject general Medical Practitioner) and received in authorised health centers and clinics. Cover is provided for eight visits to a Primary Healthcare (PHC) obstetrician for low risk, obstetrician for high risk patients referrals. Visits to include reviews, checks and tests in accordance with DHA Antenatal Care Prote investigations to include: FBC and platelets, blood group, rhesus status and antibodies, rubella serology, HIV, FBS, randoms or A1C and for high risk patients GTT and Hepatitis The cost of three antenata	nics and health cente empted from fees if ad endoscopies. In in cases that s . Subject to policies and its upda lines. years for Insured unsidered high risk. e delivery costs, pre a porisits for Pregnanc , t to referral by the patients or Specialis pocols. Initial VDRL, MSU, urinalysis C. USD 2,750 for pirth within the existin Phenylketonuria (PKL Arab Emirates.

Dubai Health Authority (DHA), as part of UAE 2021 vision and in alignment with Dubai Standards of Care has launched a **Cancer** Patient Support Program (Cancer PSP) and a **Hepatitis C** Patient Support Program (HCV PSP).

Screening, healthcare services, investigations and **Treatments** related to and associated complications related to **Cancer** shall be extended to the fund ONLY for members enrolled under the Patient Support Program (PSP) as per terms and conditions of the Program.

Screening, healthcare services, investigations and **Treatments** related to viral hepatitis and associated complications related to **Hepatitis C** shall be available ONLY for members enrolled under the Patient Support Program (PSP) as per terms and conditions of the Program.

Benefit

Excel

30. Health Authority Abu Dhabi (HAAD) Mandatory requirements Benefit:

For **Insured Persons** with residence visas in the Emirate of Abu Dhabi this **Plan** is extended to provide coverage up to USD 69,000 in aggregate per **Insured Person**, per **Period of Cover** for the following basic health services within the Emirate of Abu Dhabi and for **Emergency** services within the United Arab Emirates:

- (i) Pre-existing Conditions including Maintenance of Chronic Medical Conditions.
- Medically Necessary costs incurred during normal Pregnancy and childbirth, including pre and post natal check-ups up to the Benefit limit subject to Pre-Authorisation.
- (iii) The costs of accommodation of an accompanying person as an In-Patient in the same room in cases that are Medically Necessary at the recommendation of the Medical Practitioner or Specialist. Subject to Pre-Authorisation and up to a maximum of USD 28 per night.
- (iv) Physiotherapy by a registered Physiotherapist when referred by a Medical Practitioner or a Specialist subject to Pre-Authorisation.
- (v) Hearing and vision aids and vision corrected by surgeries where Medically Necessary and as a result of an Emergency.

Unless otherwise indicated these **Benefits** will not be payable for **Treatment** outside the United Arab Emirates. For maternity **Benefit** outside of the United Arab Emirates, the optional maternity **Benefit** must be selected. Healthcare services are covered in full for work illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulations of Work Relations, as amended and applicable laws in this respect.

Options to Core Benefits

31. USA Elective Treatment:

- (i) Costs associated with Eligible In-Patient and Day-Patient Treatment in the USA will be paid in full where Treatment is received in a Hospital listed in the Now Health International Provider Network.
- (ii) Costs associated with Eligible Out-Patient Treatment in the USA will be paid in full where Treatment is received in the Now Health International Provider Network.

Treatment that is not received in the Now Health International Provider Network will be subject to a 50% Co-Insurance.

32. Co-Insurance Out-Patient Treatment:

(not available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi) A 10% **Co-Insurance** will apply to all **Eligible Out-Patient Treatment**. Should **Your Plan** include the Maternity or Dental care **Benefits**, any applicable **Co-Insurance** will be detailed in **Your Benefit Schedule**.

Please note that the **Co-Insurance** will not apply to **Treatment** relating to Renal dialysis/ Renal failure, **Cancer** or Organ Transplants.

33. Co-Insurance Out-Patient Treatment Option 2:

(not available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi) A 20% **Co-Insurance** will apply to all **Eligible Out-Patient Treatment**. Should **Your Plan** include the Maternity or Dental care **Benefits**, any applicable **Co-Insurance** will be detailed in **Your Benefit Schedule**.

Please note that the **Co-Insurance** will not apply to **Treatment** relating to Renal dialysis/ Renal failure, **Cancer** or Organ Transplants.

34. Restricted Network – UAE residents only:

(not available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi) (only available for new **Plans** in force on or after 1 August 2015)

No **Benefit** will be payable in respect of costs associated with **Eligible In-Patient**, **Day-Patient** or **Out-Patient Treatment** made at either the American Hospital and associated clinics, City Hospital, Welcare Hospital and associated **Hospitals** and clinics of the Mediclinic Group. Please note that if **You** selected the USD 25 per visit **Out-Patient Excess** or one of the **Co-Insurance Plan** options, these will still apply in the **Restricted Network**.

Full refund

Not covered

Excel

Pre-Authorisation for

Out-Patient diagnostics

and surgery,

Day-Patient and In-Patient Treatment 🕿

Optional Up to USD 1.5m per **Insured Person** per **Period of Cover**

Optional

Ontional

Ontional

Subject to limits

Opt	ions to Core Benefits	Excel
(i) (ii (ii Fo	 Vellness, Optical and Vaccinations: Wellness: This Benefit is payable as a contribution towards the cost of routine healt checks including Cancer screening, cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol) and/or Optical Benefits: This Benefit also provides a contribution towards optician charges including an annual eye test carried out by an Opthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription ha changed, within the combined Benefit limits to a maximum USD300 per Period of Cover for an optical claim. Please note that there is no cover for prescription sunglasses or transition lenses. and/or Vaccinations: Costs of drugs and consultations to administer all Medically Necessary basic immunisation and booster injections and any Medically Necessary travel Vaccinations and malaria prophylaxis. or this Benefit exclusion 5.10 does not apply. Vating Period: Cover only available after six months of continuous membership. 	Optional Combined limi Up to USD 500 per Period of Co
(i) (ii, (ii,	 Vellness, Optical and Vaccinations Option 2: Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol) and/or Optical Benefits: This Benefit also provides a contribution towards optician charges including an annual eye test carried out by an Opthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, within the combined Benefit limits to a maximum USD600 per Period of Cover for an optical claim. Please note that there is no cover for prescription sunglasses or transition lenses. and/or Vaccinations: Costs of drugs and consultations to administer all Medically Necessary basic immunisation and booster injections and any Medically Necessary travel Vaccinations and malaria prophylaxis. or this Benefit exclusion 5.10 does not apply. Vating Period: Cover only available after six months of continuous membership. 	Optional Combined limit Up to USD 1,00 per Period of Co
Example for the second	 being received as a Day-Patient. Reasonable travel costs for a locally-accompanying person to travel to and from the Hospital to visit the Insured Person following admission as an In-Patient. Reasonable costs for non-Hospital Accommodation only for immediate pre and post-Hospital admission periods provided that the Insured Person is under the care of a Specialist. sts of Evacuation do not extend to include any air-sea rescue or mountain rescue costs at are not incurred at recognised ski resorts or similar winter sports resorts. ne Insured Member's country of choice is subject to the availability of the appropriate medical cilities being in place. Our medical advisers will determine whether the selected country as the suitable medical facility to treat the Insured Member's Eligible Medical Condition. ur medical advisers will decide the most appropriate method of transportation for the vacuation and this Benefit will not cover travel if it is against the advice of Our medical facility does not have appropriate facilities to treat the Eligible 	Pre-Authorisation Optional (i) Full refund (ii) Full refund (iii) Full refund (iii) Up to USD 200 per day Up to USD 7,50 per person, per Evacuation
M Ri Ai pe pr is pa Ch	edical Condition. epatriation n economy class airfare ticket to return the Insured Person and a locally-accompanying reson who has travelled as an escort to the site of Treatment or the Insured Person's incipal Country of Nationality or principal Country of Residence, as long as the journey made within one month of completion of Treatment. Reasonable cost of the above will be id in full. narges relating to routine Pregnancy and Pregnancy and Childbirth Medical Conditions e specifically excluded from this Benefit.	Pre-Authorisation

Full refund

Not covered

Optional

Subject to limits

Out-Patient Per Visit Excess Options	Excel
Out-Patient Per Visit Excess: A USD 25 Out-Patient Per Visit Excess will apply when You receive Eligible Out-Patient Treatment inside and outside of the Now Health International Provider Network. Please note: The Out-Patient Per Visit Excess does not apply to the Alternative Therapies Benefits. If Your Plan also includes Dental care Benefit, as detailed in Your Benefit Schedule, no Out-Patient Per Visit Excess will be applicable.	Optional USD 25
Out-Patient Per Visit Excess – Option 2: A USD 15 Out-Patient Per Visit Excess will apply when You receive Eligible Out-Patient Treatment inside and outside of the Now Health International Provider Network. Please note: The Out-Patient Per Visit Excess does not apply to the Alternative Therapies Benefits.	Optional

Out-Patient Per Visit Excess options – Please note that only option 2 is available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

Deductible Options	Excel
Standard Deductible	Nil
Optional Deductible Please note: If You choose an optional Deductible, You must also select either a Co-Insurance Out-Patient Treatment Option or a Out-Patient Per Visit Excess Option. Deductibles would apply to any Medically Necessary Treatment required under Benefit 19 and Benefit 37.	USD 1,000 USD 2,500 USD 5,000 USD 10,000 USD 15,000

Please note Deductibles are not available to Insured Persons with residence visas in the Emirates of Dubai or Abu Dhabi.

4.3.4 WorldCare Apex

Annual Maximum Plan Limit 24/7 helpline and assistance services available on all Plans USD 4.5m 1. Maintenance of Chronic Medical Conditions: Maintenance of Chronic Medical Conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, examinations, check-ups, Drugs and Dressings and/or tests up to the Benefit limits detailed following Your Entry Date. This Benefit does not cover renal failure and dialysis. Claims for this will fail under Benefit 6. Claims for Cancer will fail under Benefit 8. (I) 2. Hospital Charges, Medical Practitioner and Specialist Fees: (I) Charges for In-Patient or Day-Patient Treatment made by a Hospital including charges for accommodation (ward/semi-private or private); Diagnostic Tests: operating theatre charges including surgeon and anesthetist thateres: and charges for nursing care by a Qualified Nurse; Drugs and Dressings prescribed by a Medical Practitioner or Specialist, and surgical appliances used by the Medical Practitioner or groups includes pre and post-operative consultations while an In-Patient or Day-Patient and includes for intensive care. (I) (II) Andiary charges: Purchase and rentat of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an Eligible Medical Condition which required In-Patient or Day-Patient Hospital Treatment. Pre-Authorisation for PET application to USD 2,500 pe Medical Condition 3. Diagnostic Procedures: Medically Necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an In-Patient, Day-Patient or Out-Patient. Pre-Authorisation for PET application Full refund 5. Parent Accommodat	
Maintenance of chronic Medical Conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, seasimitations, check-ups, Drugs and Dressings and/or tests up to the Benefit limits claims for this will fall under Benefit 6. Claims for Cancer will fall under Benefit 8. Image: Second	
 (i) Charges for In-Patient or Day-Patient Treatment made by a Hospital including charges for accommodation (ward/semi-private or private). Diagnostic Tests, operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a Qualified Nurse Drugs and Dressings prescribed by a Medical Practitioner or Specialist; and surgical appliances used by the Medical Practitioner during surgery. This includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and post-operative consultations while an In-Patient or Day-Patient and includes pre and respital freatment. (ii) Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an Eligible Medical Condition which required In-Patient or Day-Patient Hospital Treatment. (iii) Ancience Transportation: Medical Practitioner or Day-Patient, Day-Patient or Out-Patient. (ii) Pre-Authorisation for PET @ Full refund (iii) Full refund (iii) Full refund (iii) Full refund (iii) Full refund <	
Medically Necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an In-Patient, Day-Patient or Out-Patient. for PET T A. Emergency Ambulance Transportation: Emergency road ambulance transport costs to or between Hospitals, or when considered Medically Necessary by a Medical Practitioner or Specialist. image: Full refund 5. Parent Accommodation: The cost of one parent staying in Hospital overnight with an Insured Person under 18 years old while the child is admitted as an In-Patient for Eligible Treatment. image: Full refund) per
Emergency road ambulance transport costs to or between Hospitals, or when considered Full refund Medically Necessary by a Medical Practitioner or Specialist. Full refund 5. Parent Accommodation: The cost of one parent staying in Hospital overnight with an Insured Person under 18 years old while the child is admitted as an In-Patient for Eligible Treatment. Full refund	ion
The cost of one parent staying in Hospital overnight with an Insured Person under 18 years old while the child is admitted as an In-Patient for Eligible Treatment .	
6 Renal Failure and Renal Dialysis:	
 (i) Treatment of renal failure, including renal dialysis on an In-Patient basis. (ii) Treatment of renal failure, including renal dialysis on a Day-Patient or Out-Patient basis. (ii) Up to USD 100,000 per Period of Cover 	
 7. Organ Transplant: (i) Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the Insured Person as a recipient. In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Benefit 12 but excluded from Benefit 7 - Organ Transplant. (ii) Medical costs associated with the donor as an In-Patient or Day-Patient, with the exception of the cost of the donor organ search. We only pay for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines. 	
8. Cancer Treatment: Treatment given for Cancer received as an In-Patient, Day-Patient or Out-Patient. Includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis. Full refund	

 9. Pregnancy and Childbirth Medical Conditions: In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. As an illustration, We would consider Treatment of the following: • Ectopic Pregnancy (where the foetus is growing outside the womb) • Hydatidiform mole (abnormal cell growth in the womb) • Retained placenta (afterbirth retained in the womb) • Placenta praevia • Eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia) • Diabetes (If You have exclusions because of Your past medical history which relate to diabetes, then You will not be covered for any Treatment for diabetes during Pregnancy) • Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth) • Miscarriage requiring immediate surgical Treatment • Failure to progress in labour 10. New Born Cover: In-Patient Treatment of premature birth (i.e. prior to age 37 weeks gestation) or an Acute Condition being suffered by a New Born baby of an Insured Person which manifests itself within 30 days following birth. Provided that the New Born baby is added to the Plan within 30 daysof birth and premium paid. Cover for multiple births will be covered up to the same limits shown. In circumstances where We require details of the New Born baby's medical history before the baby is being added to the Plan, We reserve the right to apply particular restrictions to the cover We will offer. Please refer to Section 6.5 - Adding New Born of this Members Handbook for details. 	Full refund
In-Patient Treatment of premature birth (i.e. prior to age 37 weeks gestation) or an Acute Condition being suffered by a New Born baby of an Insured Person which manifests itself within 30 days following birth. Provided that the New Born baby is added to the Plan within 30 daysof birth and premium paid. Cover for multiple births will be covered up to the same limits shown. In circumstances where We require details of the New Born baby's medical history before the baby is being added to the Plan, We reserve the right to apply particular restrictions to the cover We will offer.	
11. Hospital Accommodation for New Born Accompanying their Mother: Hospital Accommodation costs relating to a New Born baby (up to 16 weeks old) to accompany its mother (being an Insured Person) while she is receiving Eligible Treatment as an In-Patient in a Hospital.	Full refund
12. Congenital Disorder: In-Patient Treatment for a Congenital Disorder. In circumstances where a Congenital Disorder manifests itself in a New Born baby within 30 days of birth, cover for such Medical Conditions will be provided under Benefit 10 but excluded from Benefit 12 – Congenital Disorders.	Up to USD 150,00 per Period of Cov e
13. Reconstructive Surgery: Reconstructive surgery required to restore natural function or appearance following an Accident or following a Surgical Procedure for an Eligible Medical Condition , which occurred after an Insured Person's Entry Date or Start Date whichever is later.	Full refund
 14. Rehabilitation: When referred by a Specialist as an integral part of Treatment for a Medical Condition necessitating admission to a recognised Rehabilitation unit of a Hospital. Where the Insured Person was confined to a Hospital as an In-Patient for at least three consecutive days, and where a Specialist confirms in writing that Rehabilitation is required. Admission to a Rehabilitation unit must be made within 14 days of discharge from Hospital. Such Treatment should be under the direct supervision and control of a Specialist and would cover: (i) Use of special Treatment rooms (ii) Speech therapy fees (iv) Occupational therapy fees 	► Full refund
 15. In-Patient Emergency Dental Treatment: This means Emergency restorative dental Treatment required to sound, natural teeth following an Accident which necessitates Your admission to Hospital for at least one night. The dental Treatment must be received within 10 days of the Accident. This Benefit covers all costs incurred for Treatment made necessary by an accidental injury caused by an extraoral impact, when the following conditions apply: If the Treatment involves replacing a crown, bridge facing, veneer or denture, We will pay only the reasonable and customary cost of a replacement of similar type or quality If implants are clinically needed We will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead 	Full refund

This **Benefit** also covers repair or reconstruction of dentures broken following an **Accident** that necessitates the **Insured Person**'s admission to a **Hospital** for at least one night, provided that such dentures were being worn at the time of the **Accident**.

Full refund Not covered Subject to limits

Benefit	Apex
6. In-Patient Psychiatric Treatment: In-Patient Treatment in a recognised Psychiatric unit of a Hospital. All Treatment must be administered under the direct control of a Registered Psychiatrist.	Pre-Authorisation Full refund limited to 30 days per Period of Cove
7. Terminal Illness: Palliative and Hospice Care: On diagnosis of a Terminal illness, costs for any In-Patient, Day-Patient or Out-Patient Treatment given on the advice of a Medical Practitioner or Specialist for the purpose of offering temporary relief of symptoms. Charges for Hospital or hospice accommodation, nursing care by a Qualified Nurse and prescribed Drugs and Dressings are covered.	Up to USD 100,000 lifetime limit
 8. Emergency Non-Elective Treatment USA Cover: For planned trips up to 30 days of duration. Treatment by a Medical Practitioner or Specialist starting within 24 hours of the Emergency event, required as a result of an Accident or the sudden beginning of a severe illness resulting in a Medical Condition that presents an immediate threat to the Insured Person's health. Charges relating to routine Pregnancy and Pregnancy and Childbirth Medical Conditions are specifically excluded from this Benefit. 	Accident: Full refund for Accider requiring In-Patient and Day-Patient ca ullness: In-Patient and Day-Patient care up to USD 50,000 per Period of Cove Out-Patient Treatment in an Accident and Emergency Department in a Hospital up to USD 500 per Period of Cove
 Evacuation Arrangements will be made to move an Insured Person who has a critical, life-threatening Eligible Medical Condition to the nearest medical facility for the purpose of admission to Hospital as an In-Patient or Day-Patient. Reasonable expenses for: (i) Transportation costs of an Insured Person in the event of Emergency Treatment and Medically Necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying 	(i) Full refund
 person who has travelled as an escort. (ii) Reasonable local travel costs to and from medical appointments when Treatment is being received as a Day-Patient. (iii) Reasonable travel costs for a locally-accompanying person to travel to and from the Hospital to visit the Insured Person following admission as an In-Patient. 	(ii) Full refund (iii) Full refund
 (iv) Reasonable costs for non-Hospital Accommodation only for immediate pre and post-Hospital admission periods provided that the Insured Person is under the care of a Specialist. Costs of Evacuation do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts. Our medical advisers will decide the most appropriate method of transportation for the Evacuation and this Benefit will not cover travel if it is against the advice of Our medical advisers or where the medical facility does not have appropriate facilities to treat the Eligible Medical Condition. Repatriation An economy class airfare ticket to return the Insured Person and a locally-accompanying 	(iv) Up to USD 300 per day Up to USD 10,000 per person, per Evacuation
person who has travelled as an escort to the site of Treatment or the Insured Person's principal Country of Nationality or principal Country of Residence , as long as the journey is made within one month of completion of Treatment .	Full refund

Full refund

Not covered

Subject to limits

Optional

Benefit

Apex

 20. Mortal Remains: In the event of death from an Eligible Medical Condition, Reasonable and Customary Charges for: Costs of transportation of body or ashes of an Insured Person to his/her Country of Nationality or Country of Residence, or Burial or cremation costs at the place of death in accordance with reasonable and customary practice. 21. Hospital Cash Benefit: This Benefit is payable for each night an Insured Person receives In-Patient Treatment and only if an Insured Person is admitted for In-Patient Treatment before midnight, and the Treatment is received free of charge that would have otherwise been Eligible for Benefit Privately under this Plan. Cover under this Benefit is limited to a maximum of 30 nights per Period of Cover. For this Benefit exclusion 5.10 does not apply. 22. Out-Patient Charges: Medical Practitioner less including consultations, Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. Any pre-operative and post-hospitalisation consultations are payable under this Benefit. 23. Day-Patient or Out-Patient Surgery: Treatment costs for a Surgical Proceedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any ore on past-operative consultations are payable under this Benefit. 24. Out Patient Psychiatric Illness: Out-Patient Physiotherapy and Alternative Therapies: Out-Patient Physiotherapy and Alternative Enterplay: Medical Practitioner or Specialist. Out-Patient Physiotherapist, when referred by a Medical Practitioner or Specialist. Out-Patient Physiotherapist, when referred by a Medical Practitioner or Specialist. Out-Patient Physiotherapist and acupanter Treatment by a therapist, when referred by a Medical Practitioner or Specialist. Out-Patient Physiotherapist Creatment Test meeting by a Registered Physiotherapist. Out-Pat	
 This benefit is payable for each night an Insured Person receives In-Patient Treatment and only if an Insured Person is admitted for In-Patient Treatment before minipit, and the Treatment is received free of charge that would have otherwise been Eligible for Benefit privately under this Plan. Cover under this Benefit is limited to a maximum of 30 nights per Period of Cover. For this Benefit exclusion 5.10 does not apply. Cut-Patient Charges: Medical Practitioner fees including consultations: Specialist fees; Diagnostic Tests: prescribed Drugs and Dressings. Any pre-operative and post-hospitalisation consultationns are payable under this Benefit. Ca Out-Patient or Out-Patient Surgery: Treatment costs for a Surgical Procedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any pre op post-operative consultations are payable under this Benefit. Cut Patient Psychiatric Illness: Out-Patient Psychiatric Illness: Dut-Patient department. Any pre or post-operative consultations are payable under Benefit 2.2 - Out-Patient department. Any pre-operative consultations are payable under Benefit 2.2 - Out-Patient department. Any pre-operative consultations are payable under Benefit 2.2 - Out-Patient department. Any pre-operative consultations are payable under Benefit 2.2 - Out-Patient department by a Psychologist subject to 10 sessions and the cost limit under this section. Dut-Patient Psychiatric Illness: (a) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, howedical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, covered in (i). (b) Out-Patient Treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or Alyuveckic Medical Practitioner. (c)	Pre-Authorisation 🖀 (i) Full refund (ii) Up to USD 20,000
 Medical Practitioner des including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. Any pre-operative and post-hospitalisation consultationns are payable under this Benefit. 23. Day-Patient or Out-Patient Surgery: Treatment costs for a Surgical Procedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any pre or post-operative consultations are payable under Benefit 22 - Out-Patient charges. 24. Out Patient Psychiatric Illness: Out-Patient Treatment administered under the direct control of a Registered Psychiatrist when referred by a Medical Practitioner or Specialist. This Benefit includes Treatment administered by a Psychologist subject to 10 sessions and the cost limit under this section. 25. Out-Patient Physiotherapy and Alternative Therapies: (1) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. (2) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. (3) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. (4) Contentary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. (5) Contentary medicine and acupuncture Treatment but excludes Physiotherapist covered in (h). (6) Out-Patient Treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. We do not cover charges for general chiropody or podiatry. For this Benefit the Plan Out-Patient Per Visit Excess does not apply. 26. Nursing Care at Home: (a) Care given by Qualified Nurse in the Insured Person's own hom	U SD 275 per night
 Treatment costs for a Surgical Procedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any pre or post-operative consultations are payable under Benefit 22 - Out-Patient charges. Cut-Patient Psychiatric Illness: Out-Patient Treatment administered under the direct control of a Registered Psychiatrist when referred by a Medical Practitioner or Specialist. This Benefit includes Treatment administered by a Psychologist subject to 10 sessions and the cost limit under this section. Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist. (i) Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist. (ii) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). (iii) Out-Patient Treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. We do not cover charges for general chiropody or podiatry. For this Benefit the Plan Out-Patient Per Visit Excess does not apply. 	Full refund
 Out-Patient Treatment administered under the direct control of a Registered Psychiatrist when referred by a Medical Practitioner or Specialist. This Benefit includes Treatment administered by a Psychologist subject to 10 sessions and the cost limit under this section. 25. Out-Patient Physiotherapy and Alternative Therapies: Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist. Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). Out-Patient Treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. We do not cover charges for general chiropody or podiatry. For this Benefit the Plan Out-Patient Per Visit Excess does not apply. 26. Nursing Care at Home: (i) Care given by Qualified Nurse in the Insured Person's own home, which is immediately received subsequent to Treatment as an In-Patient or Day-Patient on the 	Full refund
 (i) Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist. (ii) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). (iii) Out-Patient Treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. We do not cover charges for general chiropody or podiatry. For this Benefit the Plan Out-Patient Per Visit Excess does not apply. 26. Nursing Care at Home: (i) Care given by Qualified Nurse in the Insured Person's own home, which is immediately received subsequent to Treatment as an In-Patient or Day-Patient on the 	Up to USD 7,500 and subject to a maximum of 10 sessions per Period of Cover
 (i) Care given by Qualified Nurse in the Insured Person's own home, which is immediately received subsequent to Treatment as an In-Patient or Day-Patient on the 	(i) Full refund (iii) and (iii) Full refund Pre-Authorisation for (i), (ii) and (iii) after every 10 visits ☎
recommendation of a Medical Practitioner or Specialist . (ii) Medical Practitioner (GP) home visits for an Emergency GP home call-out during out of normal clinic hours.	 (i) Full refund up to 120 days per Medical Condition Pre-Authorisation for (i) 2 (ii) Up to five visits per Period of Cover

		-
27.	 ADDS: Medical expenses, which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. As result of proven occupation Accident* or blood transfusion*. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, Drugs and Dressings (except experimental or those unproven), Hospital Accommodation and nursing fees. * for members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation; and they contracted the HIV infection three years after the Entry Date or Start Date, whichever is later; and the incident from which they contracted the HIV infection accidental. ** As long as the blood transfusion was received as an In-Patient as part of Medically Necessary Treatment. Waiting Period: Cover only available after three years of continuous membership. 	Pre-Authorisa Up to USD per Period o
	Maternity: Medically Necessary costs incurred during normal Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy. Waiting Period: Costs incurred within 12 months from the Start Date are excluded. Please note that this Waiting Period does not apply to Insured Persons with resident visas for delivery within the Emirates of Dubai and Abu Dhabi. Please note, We do not pay for parenting or other teaching classes as these are a matter of personal choice. For this Benefit exclusion 5.26 does not apply. The Plan Deductible would apply to this Benefit. Please note Deductibles are not available to Insured Persons with residence visas in the Emirates of Dubai or Abu Dhabi.	► Up to USD per Period c
29.	Dental Care:	
	 (i) Routine dental Treatment: Fees of a registered Dental Practitioner carrying out routine dental Treatment in a dental surgery. Routine dental Treatment means: Screening (twice per year), i.e. the assessment of diseased, missing and filled teeth, including X-rays where necessary, Preventive scaling, polishing, and sealing (once per year), Fillings (standard amalgam or composite fillings) and extractions, and Root-canal Treatment (but not the fitting of a crown following root-canal Treatment). No other Treatment is covered under the routine dental Treatment benefit. Waiting Period: Costs incurred within nine months from the Start Date are excluded. A Co-Insurance of 20% applies. For this Benefit the Plan Deductible or Plan Out-Patient Per Visit Excess does not apply. 	(i) Up to USD per Period c
	 (iii) Complex Dental Treatment: Fees of a registered Dental Practitioner and associated costs for the following procedures: Eligible complex dental Treatment: including for example, Apicoectomy done to treat the following – Fractured tooth root; A severely curved tooth root; Teeth with caps or posts; Cyst or infection which is untreatable with root canal therapy; Root perforations; New or repair of crowns, dentures, in lays and bridges. Recurrent pain and infection; Persistent symptoms that do not indicate problems from x-rays. Calcification; Damaged root surfaces and surrounding bone requiring surgery. No other Treatment is covered by this Benefit. Waiting Period: Costs incurred within nine months from the Start Date are excluded. A Co-Insurance of 20% applies. A 50% Co-Insurance applies in respect of all orthodontic Treatment. 	(ii) Up to USD per Period d

Full refund

Not covered > Subject to limits

▶ Optional

Benefit

30. Dubai Health Authority (DHA) Mandatory requirements Benefit:

This **Plan** provides coverage up to USD 41,000 in aggregate per **Insured Person**, per **Period of Cover** for the following basic health services inclusive of **Emergency** services within the United Arab Emirates:

- (i) Pre-existing Conditions including maintenance of Chronic Medical Conditions
- (ii) Examinations, diagnostic and Treatment services (including cost of medicine) received in clinics and health centers that are provided by general Medical Practitioners and Specialists. Follow up visits are exempted from fees if made within a week from the date of the first examination.
- (iii) Laboratory tests, X-ray diagnostic services, diagnostic procedures including MRI, CT scans and endoscopies.
- (iv) Out-Patient physiotherapy Maximum 10 sessions per year.
- (v) The costs of accommodation of an accompanying person as an In-Patient in the same room in cases that are Medically Necessary at the recommendation of the Medical Practitioner or Specialist. Subject to Pre-Authorisation and up to a maximum of USD 28 per night.
- (vi) Essential Vaccinations and inoculations for newborns and children as stipulated in the DHA policies and its updates, in assigned facilities.
- (vii) Adult Pneumococcal Conjugate Vaccine as per DHA Adult Pneumococcal Vaccination guidelines.
- (viii) Preventive screening for diabetes and other screening as stipulated by the DHA every three years for **Insured Persons** above the age of 30 and every year for 18 years and above for **Insured Persons** considered high risk.
- (ix) Cover is provided for a **New Born** baby of an **Insured Person** for a period of 30 days from birth within the existing aggregate limit of the Mother. This includes BCG, Hepatitis B and neo-natal screening tests (Phenylketonuria (PKU), Congenital Hypothyroidism, sickle cell screening, congenital adrenal hyperplasia).

Unless otherwise indicated these **Benefits** will not be payable for **Treatment** outside the United Arab Emirates. No maternity **Waiting Period** applies on the Dubai Health Authority (DHA) Mandatory requirements **Benefit**.

BASMAH Initiative:

Dubai Health Authority (DHA), as part of UAE 2021 vision and in alignment with Dubai Standards of Care has launched a **Cancer** Patient Support Program (Cancer PSP) and a **Hepatitis C** Patient Support Program (HCV PSP).

Screening, healthcare services, investigations and **Treatments** related to and associated complications related to **Cancer** shall be extended to the fund ONLY for members enrolled under the Patient Support Program (PSP) as per terms and conditions of the Program.

Screening, healthcare services, investigations and **Treatments** related to viral hepatitis and associated complications related to **Hepatitis C** shall be available ONLY for members enrolled under the Patient Support Program (PSP) as per terms and conditions of the Program.

31. Health Authority Abu Dhabi (HAAD) Mandatory requirements Benefit:

For **Insured Persons** with residence visas in the Emirate of Abu Dhabi this **Plan** is extended to provide coverage up to USD 69,000 in aggregate per **Insured Person**, per **Period of Cover** for the following basic health services within the Emirate of Abu Dhabi and for **Emergency** services within the United Arab Emirates:

- (i) Pre-existing Conditions including Maintenance of Chronic Medical Conditions.
- (ii) Medically Necessary costs incurred during normal Pregnancy and childbirth, including pre and post natal check-ups up to the Benefit limit subject to Pre-Authorisation.
- (iii) The costs of accommodation of an accompanying person as an In-Patient in the same room in cases that are Medically Necessary at the recommendation of the Medical Practitioner or Specialist. Subject to Pre-Authorisation and up to a maximum of USD 28 per night.
- (iv) Physiotherapy by a registered Physiotherapist when referred by a Medical Practitioner or a Specialist subject to Pre-Authorisation.
- (v) Hearing and vision aids and vision corrected by surgeries where Medically Necessary and as a result of an Emergency.

Unless otherwise indicated these Benefits will not be payable for Treatment outside the United Arab Emirates.

For maternity **Benefit** outside of the United Arab Emirates, the optional maternity **Benefit** must be selected. Healthcare services are covered in full for work illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulations of Work Relations, as amended and applicable laws in this respect.

Options to Core Benefits

32. USA Elective Treatment:

- (i) Costs associated with Eligible In-Patient and Day-Patient Treatment in the USA will be paid in full where Treatment is received in a Hospital listed in the Now Health International Provider Network.
- (ii) Costs associated with **Eligible Out-Patient Treatment** in the USA will be paid in full where **Treatment** is received in the **Now Health International Provider Network**.

Treatment that is not received in the Now Health International Provider Network will be subject to a 50% Co-Insurance.



Pre-Authorisation

for Out-Patient

diagnostics and

surgery, Day-Patient

and In-Patient

Treatment 🖀

🕨 Full refund 🛛 🕨 Not covered 🔶 Subject to limits 🕨 Optional

(I F ir ir P	Co-Insurance Out-Patient Treatment: not available to Insured Persons with residence visas in the Emirate of Abu Dhabi) A 10% Co-Insurance will apply to all Eligible Out-Patient Treatment . Should Your Plan include the Maternity or Dental care Benefits , any applicable Co-Insurance will be detailed on Your Benefit Schedule . Nease note that the Co-Insurance will not apply to Treatment relating to Renal dialysis/ tenal failure, Cancer or Organ Transplants.	Optional
(I F ir P	Co-Insurance Out-Patient Treatment Option 2: not available to Insured Persons with residence visas in the Emirate of Abu Dhabi) A 20% Co-Insurance will apply to all Eligible Out-Patient Treatment. Should Your Plan Include the Maternity or Dental care Benefits, any applicable Co-Insurance will be detailed on Your Benefit Schedule. Please note that the Co-Insurance will not apply to Treatment relating to Renal dialysis/ Itenal failure, Cancer or Organ Transplants.	Optional
(r (c 0 0 0 0 0	Restricted Network – UAE Residents only: not available to Insured Persons with residence visas in the Emirate of Abu Dhabi) only available for new Plans in force on or after 1 August 2015) I/O Benefit will be payable in respect of costs associated with Eligible In-Patient, Day-Patient or Out-Patient Treatment made at either the American Hospital and associated clinics, i'ty Hospital, Welcare Hospital and associated Hospitals and clinics of the Mediclinic Group. Wease note that if You selected the USD 25 per visit Out-Patient Excess or one of the To-insurance Plan options, these will still apply in the Restricted Network.	D Optional
() () ()	 Wellness, Optical and Vaccinations: Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol) and/or Optical Benefits: This Benefit also provides a contribution towards optician charges including an annual eye test carried out by an Opthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, within the combined Benefit limits to a maximum USD 300 per Period of Cover for an optical claim. Please note that there is no cover for prescription sunglasses or transition lenses. and/or Waccinations: Costs of drugs and consultations to administer all Medically Necessary basic immunisation and booster injections and any Medically Necessary travel Vaccinations and malaria prophylaxis. For this Benefit exclusion 5.10 does not apply. Waiting Period: Cover only available after six months of continuous membership. 	Optional Combined limi Up to USD 500 per Period of Co
(i, (i (i	 Wellness, Optical and Vaccinations Option 2: Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol) and/or Optical Benefits: This Benefit also provides a contribution towards optician charges including an annual eye test carried out by an Opthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, within the combined Benefit limits to a maximum USD 600 per Period of Cover for anoptical claim. Please note that there is no cover for prescription sunglasses or transition lenses. and/or Vaccinations: Costs of drugs and consultations to administer all Medically Necessary basic immunisation and booster injections and any Medically Necessary travel Vaccinations and malaria prophylaxis. For this Benefit exclusion 5.10 does not apply. Waiting Period: Cover only available after six months of continuous membership. 	Optional Combined limit Up to USD 1,00 per Period of Co

Full refund

Not covered

Subject to limits

Optional

Options to Core Benefits	Apex
<section-header><section-header><section-header><section-header><text><text><list-item><list-item><list-item><list-item></list-item></list-item></list-item></list-item></text></text></section-header></section-header></section-header></section-header>	Pre-Authorisation Coptional (i) Full refund (ii) Full refund (iii) Full refund (iv) Up to USD 300 per day Up to USD 10,000 per person, per Evacuation Pre-Authorisation Composition
Out-Patient Per Visit Excess Options	Apex
Out-Patient Per Visit Excess: A USD 25 Out-Patient Per Visit Excess will apply when You receive Eligible Out-Patient Treatment inside and outside of the Now Health International Provider Network. Please note: The Out-Patient Per Visit Excess does not apply to the Alternative Therapies Benefits. If Your Plan also includes Dental care Benefit, as detailed in Your Benefit Schedule, no Out-Patient Per Visit Excess will be applicable.	Optional USD 25
Out-Patient Per Visit Excess – Option 2 A USD 15 Out-Patient Per Visit Excess will apply when You receive Eligible Out-Patient Treatment inside and outside of the Now Health International Provider Network. Please note: The Out-Patient Per Visit Excess does not apply to the Alternative Therapies Benefits.	Optional USD 15

Out-Patient Per Visit Excess options - Please note that only option 2 is available to Insured Persons with residence visas in the Emirate of Abu Dhabi.

If Your Plan also includes Dental care Benefit, as detailed in Your Benefit Schedule,

no Out-Patient Per Visit Excess will be applicable.

Deductible Options	Арех
Standard Deductible	Nil
Optional Deductible	USD 1,000 USD 2.500
Please note: If You choose an optional Deductible, You must also select either a Co-Insurance Out-Patient Treatment Option or a Out-Patient Per Visit Excess Option.	USD 5,000 USD 10,000
Deductibles would apply to any Medically Necessary Treatment under Benefit 19 and Benefit 38.	USD 15,000

Please note **Deductibles** are not available to Insured Persons with residence visas in the Emirates of Dubai or Abu Dhabi

Full refund Not covered Subject to limits Optional

5. Exclusions: What is not covered?

These are the **Plan** limitations that apply in addition to any personal exclusions detailed in **Your Certificate of Insurance**. These include **Treatments** that may be considered a matter of personal choice (such as cosmetic **Treatment**) and other **Treatments** that are excluded from cover to keep premiums at an affordable level.

5.1 Act of Terrorism, war and illegal acts

We do not pay for **Treatment** of any condition resulting directly or indirectly from, or as a consequence of war, acts of foreign hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, or attempted overthrow of government, or any acts of terrorism, unless **You** are an innocent bystander. **You** are not covered for costs arising from taking part in any illegal act.

5.2 Administrative and shipping fees

You are not covered for any charges made by a **Medical Practitioner** or **Dental Practitioner** for filling in claim forms or providing medical reports. **You** are not covered for any charges where a police report is required. **You** are not covered for the cost of shipping (including customs duty) on transporting medication.

5.3 Alcohol and drug abuse

You are not covered for costs for **Treatment** resulting from dependency on or abuse of alcohol, drugs, or other addictive substances and any illness or injury arising directly or indirectly from such dependency or abuse.

5.4 Allergy Testing

You are not covered for any allergy testing even when prescribed by a physician.

5.5 Chemical exposure

You are not covered for **Treatment** costs directly or indirectly caused by or contributed to or arising from: ionizing radiations or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel; the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

5.6 Cosmetic Treatment

You are not covered for **Treatment** costs relating to cosmetic or aesthetic **Treatment** or any **Treatment** related to previous cosmetic or reconstructive surgery (whether or not for psychological purposes) to enhance **Your** appearance, even when medically prescribed, such as but not limited to acne, teeth whitening, lentigo and alopecia.

The only exception is an initial reconstructive surgery necessary to restore function or appearance after a disfiguring **Accident**, or following a **Surgical Procedure** for an **Eligible Medical Condition** if the **Accident** or surgery occurs during **Your** membership.

5.7 Contamination

We do not pay for the **Treatment** of any conditions, or for any claim arising directly or indirectly from chemical or biological contamination, however caused, or from contamination by radioactivity from any nuclear material whatsoever, or asbestosis, including expenses in any way caused by or contributed to by an act of war or terrorism.

5.8 Chronic Conditions

If **You** are insured under the Essential **Plan** option, **You** do not have cover for costs relating to the maintenance of **Chronic Conditions**.

5.9 Coma or Vegetative State

We will not pay for any **Treatment** costs incurred by an **Insured Person** after being in a coma or in a vegetative state for more than 12 months.

We will, however, pay for any active **Treatment** costs of an **Eligible Medical Condition** incurred within the first 12 months of the coma or the vegetative state.

5.10 Deductible, Out-Patient Per Visit Excess or Co-Insurance

You are not covered for the amount of the **Deductible**, **Out-Patient Per Visit Excess** or **Co-Insurance** that is shown on **Your Certificate of Insurance**. We will treat any arrangement with or any offer by a provider to charge **Us** a higher fee to cover the amount of the **Deductible**, **Out-Patient Per Visit Excess** or **Co-Insurance** as fraud and **We** will take legal action.

5.11 Dental care

You are not covered for any dental care unless these **Benefits** are included on **Your Certificate of Insurance**. However **We** will pay for **Emergency In-Patient** dental **Treatment** following an **Accident** as detailed in the **Benefit Schedule**. **We** will not pay for any telephone or travelling expenses incurred in seeking dental advice or **Treatment**, damage to dentures unless being worn at the time of the **Accident**, or the cost of **Treatment** made necessary by an accidental dental injury if:

- The injury was caused by eating or drinking anything, even if it contains a foreign body
- The damage was caused by normal wear and tear
- The injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth
 protection was worn
- The injury was caused by any means other than extra-oral impact
- The damage was caused by tooth brushing or any other oral hygiene procedure
- The damage is not apparent within 10 days of the impact which caused the injury
- The costs are incurred more than 18 months after the date of the injury which made the Treatment necessary

5.12 Developmental disorders

You are not covered for **Treatment** of developmental, behavioural or learning problems such as attention deficit hyperactivity syndrome, speech disorders or dyslexia and physical developmental problems.

5.13 Dietary supplements, vitamins or minerals and Cosmetic Products

We do not pay for products classified as vitamins or minerals (except during **Pregnancy** or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary consultations and supplements, including, but not limited to, special infant formula and cosmetic products including but not limited to moisturizers, cleansers, lotions, soaps, shampoos, sunscreen, mouth wash, antiseptic lozenges, even if medically recommended or prescribed or acknowledged as having therapeutic effects.

5.14 Eating disorders

You are not covered for costs relating to **Treatment** of eating disorders such as, but not limited to, anorexia nervosa and bulimia.

5.15 Experimental Treatment and drugs

You are not covered for **Treatment** or drugs which have not been established as being effective or which are experimental. For drugs this means they must be licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and be used within the terms of that licence. For established **Treatment**, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced and published medical journals and/or been approved by the National Institute for Health and Clinical Excellence for specific purposes to be considered proven safe and effective therapies.

5.16 Eyesight tests or vision correction, hearing tests, hearing or visual aids

You are not covered for routine eyesight or hearing tests or the cost of eyeglasses, contact lenses, hearing aids or cochlear implants. We do not pay for eye surgery to correct vision, however eye surgery to correct an Eligible Medical Condition is covered.

5.17 External appliance and/or Prosthesis

You are not covered for any costs relating to providing, maintaining and fitting of any external prosthesis or appliance or other equipment, medical or otherwise except as is specified under the Hospital Charges, Medical Practitioner and Specialist fees Benefit.

5.18 Failure to follow medical advice

We do not pay for **Treatment** arising from or related to **Your** unreasonable failure to seek or follow medical advice and/or prescribed **Treatment**, or **Your** unreasonable delay in seeking or following such medical advice and/or prescribed **Treatment**. We do not pay for complications arising from ignoring such advice.

5.19 Foetal surgery

We do not cover the costs of surgery on a child while in its mother's womb except as part of the maternity **Benefits** detailed in **Your Certificate of Insurance**.

5.20 Genetic testing

We do not cover the cost of genetic tests, when those tests are undertaken to establish whether or not You may be genetically disposed to the development of a Medical Condition, You have a Medical Condition when You have no symptoms or if there is a genetic risk of You passing on a Medical Condition.

5.21 Hazardous sports and pursuits

We do not cover **Treatment** of injuries sustained from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 30 metres, trekking to a height of over 4,000 metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.

5.22 HIV, AIDS or sexually transmitted disease

You are not covered for **Treatment** for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by or related to Human Immunodeficiency Virus (HIV) (or both) and sexually transmitted disease, other than stated in the **Benefit Schedule**. HIV test when not medically prescribed or screening for visa application purposes are not covered.

5.23 Hormone Replacement Therapy

You are not covered for the costs of **Treatment** for Hormone Replacement Therapy (HRT). We will cover **Medical Practitioner's** fees including consultations, the cost of implants, patches or tablets which are **Medically Necessary** as a direct result of medical intervention, up to a maximum of 18 months from the date of medical intervention.

5.24 Morbid obesity

You are not covered for the costs of **Treatment** for, or related to, morbid obesity. You are not covered for costs arising from or relating to removing fat or surplus healthy tissue from any part of the body.

5.25 Nursing homes, convalescence homes, health hydros, and nature cure clinics

You are not covered for **Treatment** received in nursing homes, convalescence homes, health hydros, nature cure clinics or similar establishments. You are not covered for convalescence or where You are in **Hospital** for the purpose of supervision. You are not covered for extended nursing care if the reason for the extended nursing care is due to age related infirmity and/or if the **Hospital** has effectively become Your home.

5.26 Pregnancy or maternity

You are not covered for costs relating to normal **Pregnancy** or childbirth, voluntary caesarean section, unless maternity **Benefits** are shown on **Your Certificate of Insurance**.

5.27 Pre-Existing Medical Conditions

Your Plan does not cover You for Treatment of Pre-Existing Medical Conditions and Related Conditions unless accepted by Us in writing.

A Pre-Existing Medical Condition means any disease, injury or illness for which:

- You have received Treatment, tests or investigations for, been diagnosed with or been hospitalised for; or
- You have suffered from or experienced symptoms; whether the Medical Condition has been diagnosed or not, at any time before Your Start Date/Entry Date into the Plan.

5.28 Professional sports

You are not covered for any costs resulting from injuries or illness arising from **You** taking part in any form of professional sport. By professional sport, **We** mean where **You** are being paid to take part.

5.29 Reproductive medicine

You are not covered for costs relating to investigations into or **Treatment** of infertility and fertility, sterilisation (or its reversal) or assisted conception. You are not covered for the costs in connection with contraception.

5.30 Routine examinations, health screening

You are not covered for routine medical examinations including issuing medical certificates, health screening examinations or tests to rule out the existence of a condition for which **You** do not have any symptoms, unless these **Benefits** are shown on **Your Certificate of Insurance**.

5.31 Second opinions

We do not cover the costs of any second or subsequent medical opinions from a Medical Practitioner or Specialist for the same Medical Condition other than stated in Your Certificate of Insurance, unless authorised by Us.

5.32 Self-inflicted injuries or attempted suicide

You are not covered for any costs for **Treatment** resulting directly or indirectly from self-inflicted injury, suicide or attempted suicide.

5.33 Sexual problems and gender re-assignment

You are not covered for **Treatment** costs relating to sexual problems including sexual dysfunction or gender re-assignment operations or any other surgical or medical **Treatment** including psychotherapy or similar services which arise from, or are directly or indirectly associated with gender re-assignment. **You** are not covered for the costs of treating sexually transmitted infections.

5.34 Sleep disorders

You are not covered for Treatment costs related to snoring, insomnia, jet-lag, fatigue, or sleep apnoea including sleep studies or corrective surgery.

5.35 Travel/accommodation costs

You are not covered for transport or accommodation costs You incur during trips made specifically to get medical **Treatment** unless these costs are for an **Emergency** medical **Evacuation** that **We** pre-authorise. You are not covered for any costs of **Emergency** medical **Evacuation** or repatriating **Your** body that **We** did not pre-authorise and arrange.

5.36 Travelling against medical advice

You are not covered for medical or other costs You incur if You travel against the advice given by Your treating Medical Practitioner.

5.37 Treatment by a family member

You are not covered for the costs of Treatment by a family member or for self-therapy.

5.38 Treatment charges outside of Our reasonable and customary range

We will not pay Treatment charges when they are above the Reasonable and Customary Charges level.

6. Plan administration

6.1 The contract

The application form and any supporting documents, **Certificate of Insurance**, **Benefit Schedule** and this handbook incorporating the **Plan** terms and conditions make up the contract between **You** and **Us**.

6.2 Premium payment

At the start of each **Plan** year, **We** will calculate **Your** new premium and let **You** know how much it is. **We** offer a choice of monthly, quarterly, semi-annual or annual premiums, which can be paid by credit card. Bank transfers or cheques can be used for annual premiums only. Premiums are payable for each person covered and any increase will normally take effect from the annual **Renewal Date** of **Your** membership.

If **You** pay by credit card, bank transfer or cheque, **We** will collect the first premium when **Your Plan** starts and subsequent premiums when they fall due. However **You** pay **Your** premium at the moment, bear in mind that **You** can change to another method simply by contacting **Our** Customer Service team on +971 (0) 4450 1415.

You must pay Your premium when it is due. Depending on Your preferred payment method, You must pay Us before the Start Date, the due date or within 30 days of Our written acceptance at the latest, if a cover note is issued. If You do not, We will cancel Your Plan and will not pay for any Treatment or Benefit entitlement arising after the date that the premium became due.

We make every effort to maintain premiums at as low a level as possible, without compromising the range and quality of the cover provided. We review premiums each year to take account of a range of statistical factors.

Typically the cost of premiums increases at a level higher than the Retail Price Index (RPI). **You** will receive reasonable notice of any changes in premium. **Your** premium will also include the amount of any insurance premium tax or other taxes or levies which are payable by law in respect of **Your Plan**.

Premiums are based on age at the **Entry Date** or subsequent **Renewal Date**. When the **Dependant** child is an **Insured Person**, the current age shown in the premium tables will apply.

6.3 Eligibility

6.3.1 Age limits

The maximum entry age is 79. You must be under 80 years of age at the Entry Date of Your Plan.

6.3.2 Full medical underwriting

Full medical underwriting requires each person to be covered by **Our Plan** to complete and return an application form including the medical declaration. If **You** answer "Yes" to any of the questions, **You** will be required to provide details of the date of, and diagnosis; past/current and future known **Treatment**; details of the frequency and severity of symptoms including the date of the last episode. If available, **You** should provide any medical reports or test results with **Your** application. **You** may be required to complete a further medical questionnaire if **We** require more information. All information will be treated in strict confidence.

We rely on the information that You provide in the application form when We decide whether or not to accept Your application, and whether or not We need to apply special terms. Special terms are exclusions or conditions that We may apply to Your cover. If You submit a claim for the Treatment of any condition which You omitted to tell Us about here, or You omit to tell Us everything about any condition, We may refuse to pay that claim. We will tell You about any excluded Medical Conditions, restriction of coverage, and/or additional loading on Your Certificate of Insurance.

6.3.3 Dependants

Dependants must be covered under the same level of **Benefits You** have, as the **Planholder**. For example, if the **Insured Person** has elected for the Excel **Plan** option; they can decide to cover their **Dependant** under the same **Plan** option but not Essential, Advance or Apex **Plan** options.

6.3.4 Start Date

Cover starts on the **Start Date** shown on **Your Certificate of Insurance** provided **We** have received **Your** premium payment. Depending on the preferred premium payment method, a cover note may be issued and premiums will be due within 30 days of **Our** written acceptance.

6.3.5 Local legislation

Membership may depend on local insurance licensing legislation in **Your Country of Residence**. **You** are obliged to meet local legislation requirements in **Your Country of Residence** at any time before and while **You** are a member of this **Plan**.

6.3.6 Non-Eligible residency

If **You** permanently reside in a country that is not covered by this **Plan** and which **We** have advised at **Renewal Date**, **You** are not **Eligible** for this **Plan**. For details of the excluded countries please contact **Our** Customer Service team on +971 (0) 4450 1415.

6.4 Adding a new Dependant

If subsequently **You** wish to add **Your** spouse, partner or child to **Your Plan**, **You** must either use **Your** online secure portfolio area at www.now-health.com or complete an add dependant application form. Cover will not start until **Your** application has been accepted by **Us** for that **Dependant** and **We** have received premium payment.

There will be No backdating of additions for Dubai Residents with the exception of **New Born** babies whose addition can be backdated up to 7 days from the date of birth.

6.5 Adding New Borns

You can apply to add **New Born** babies (who are born to the **Planholder** or the **Planholder's** spouse) to the **Plan** from their date of birth. This can normally be done without filling out details of their medical history, provided **You** add them within 30 days of their date of birth. **You** can do this by applying via **Your** online secure portfolio area at www.now-health.com.

However, We will require details of the baby's medical history if :

- the baby was born within 10 months from Your Start Date or Your spouse's Start Date, whichever date is later; or
- the baby has been adopted; or
- the baby was born as the result of any method of assisted conception or following any type of fertility Treatment, including but not limited to fertility drug Treatment.

In such circumstances **We** reserve the right to apply particular restrictions to the cover **We** will offer, and **We** will notify **You** of those terms as soon as reasonably possible. This may limit **Your** baby's cover for existing **Medical Conditions**. This would mean that **Your** baby will not be covered for **Treatment** carried out for **Medical Conditions** which existed prior to joining, such as **Treatment** in a Special Care Baby Unit and **You** will be liable for these costs.

6.6 Changing Your cover

Subsequent changes in cover can only be made at renewal.

6.7 Renewing Your cover

Your Plan is for one year, the **Period of Cover**. Prior to the end of any **Period of Cover We** will write to the **Planholder** to advise on what terms the **Plan** will continue, provided the **Plan You** are on is still available. If **We** do not hear from the **Planholder** in response, **We** will renew **Your Plan** on the new terms.

Where **You** have opted to pay premiums by continuous credit card payments or other payment method, **We** may continue to collect premiums by such method for the new **Plan** year. Please note that if **We** do not receive **Your** premium, **You** will not be covered. If the **Plan You** were on is no longer available, **We** will do **Our** best to offer **You** cover on an alternative **Plan**.

6.8 Continuous transfer terms

We will maintain Your existing underwriting or special acceptance terms, as shown by Your current insurer, such as any moratoria or specific exclusions and Your Plan with Us will be governed by the terms and conditions of this Plan. The acceptance by Us of Your original Start Date will be applied to Your Plan with Us and any transfer will be subject to no enhanced Benefits being provided. Transfer from a Company Plan to an Individual Plan is subject to written agreement from Us.

Please note that this option is not available for visa holders within the Emirates of Dubai or Abu Dhabi.

6.9 Local taxes

You are liable for any local taxes and charges as established by the applicable laws. These have to be paid in full by You and will be shown on Your Certificate of Insurance.

7. Making a complaint

7.1 What should I do if I have reason to complain?

We aim to provide You with a simple and straightforward service. Providing You with clear and accurate information, whether in writing or by telephone, is an important part of this service. Our Customer Services team is there to help You get the best from Your Now Health membership. They can help You when You make a claim, as well as remind You of restrictions You may have on Your Plan (please remember that Your Plan is not intended to cover all eventualities).

If **You** are dissatisfied with the service **We** have provided or if **You** feel that **We** have made a wrong decision, **We** will of course try to address **Your** concerns. **Your** feedback helps **Us** improve **Our** service to **You**.

Step 1

If **You** are dissatisfied with any service **You** have received from **Us**, please contact **Our** Customer Services team on T +971 (0) 4450 1415 in the first instance. They will try to resolve **Your** complaint. **Our** aim is to resolve the vast majority of customer complaints satisfactorily at this stage.

Step 2

If **You** are unhappy with the response **You** receive from the Customer Services team, **We** ask **You** to write to **Us** at the following address:

Head of Customer Service

Arabia Insurance Company S.A.L., c/o Now Health International Gulf Third Party Administrators LLC, Unit 3701, Burj Al Salam Building, 3 Sheikh Zayed Rd, PO Box 334337, Dubai, United Arab Emirates.

If You need to call the Head of Customer Service, the number is +971 (0) 4450 1415.

You can also make a complaint directly from Your online secure portfolio area at www.now-health.com.

We will acknowledge Your complaint upon receipt, investigate it and reply to You within five working days of receiving Your letter. If there is an unavoidable delay, We will inform You of this.

Step 3

If **You** are dissatisfied with the response **You** receive at step 2, please write to **Our** Managing Director, detailing why **You** feel **Our** decision is incorrect in relation to the terms and **Benefits** of **Your** Plan. The address is:

The Managing Director

Arabia Insurance Company S.A.L., c/o Now Health International Gulf Third Party Administrators LLC, Unit 3701, Burj Al Salam Building, 3 Sheikh Zayed Rd, PO Box 334337, Dubai, United Arab Emirates.

You can also email the Managing Director at CustomerService@now-health.com

We will acknowledge Your letter upon receipt. Our Managing Director will review Your complaint and respond to You within 10 working days of receiving Your letter. If there is an unavoidable delay, We will inform You of this.

Step 4

If **You** are dissatisfied with **Our** final response or dissatisfied with the delay in **Our** response, **You** have a right to refer **Your** complaint to the Dubai Health Authority (ipromes.eclaimlink.ae) or Health Authority of Abu Dhabi (in case of Abu Dhabi medical policies) and / or Insurance Authority (in all cases) with **Your** complaint.

Insurance Authority P.O Box 113332, Abu Dhabi, United Arab Emirates Telephone: +971 2499 0111 Fax: +971 2557 2111 Email: contactus@ia.gov.ae Website: www.ia.gov.ae

8. Rights and responsibilities

The application form, **Certificate of Insurance**, **Benefit Schedule** and this handbook incorporating the **Plan** terms and conditions make up the contract between **You** and **Us** with the purpose of providing **You** with **Benefit** when **You** need medical **Treatment**.

8.1 Your rights and responsibilities

- 8.1.1 You must make sure that whenever You are required to give Us any information, all the information You give Us is sufficiently true, accurate and complete so as to give Us a fair presentation of the risk We are taking on (these are Your representations to Us). If We discover later it is not and that Your representations were deliberate, reckless or careless, then We may void the Plan (including not returning the Plan premium) or apply different terms of cover in line with the terms We would have applied had the information been presented to Us fairly in the first place. These terms may increase the Plan premium and reduce Your claim(s).
- 8.1.2 You must write and tell Us if You change Your address or occupation.
- 8.1.3 This Plan is available only to people living outside their Country of Nationality apart from certain countries where We have explicitly agreed to cover local nationals, so You must tell Us immediately if You or any family member has gone to live in Your Country of Nationality which means they will be in that country for more than six months in the year. You must tell Us if You change Your principal Country of Residence. If You don't tell Us We can refuse to pay Benefits claimed for.
- 8.1.4 Only We and the Planholder have legal rights under this Plan and it is not intended that any clause or term of this Plan should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any family member.
- 8.1.5 If the **Planholder** dies and there is more than one **Insured Person** aged 18 or above, this **Plan** will automatically be transferred to the oldest **Insured Person** from the date of death, who will become the **Planholder**.
- 8.1.6 You must pay Your premium when it is due and in the currency of Your Plan. We will decide the amount at the start of each year and tell You how much it is. You can pay it in the way You have agreed with Us. We can change the amount of Your premium during a year to reflect any change in insurance premium tax or other taxes but We will tell You of the change. If Your premium payments are not up to date Your Plan will end.
- 8.1.7 The Planholder may cancel this Plan by contacting Us during the 14-day cooling off period. The 14-day cooling off period starts on the day that the contract is concluded or the day that full Plan terms and conditions are received, whichever is the later. The 14-day cooling off period also applies from each Renewal Date.

If the **Plan** is cancelled during the 14-day cooling off period **We** will return any premium paid for the **Plan** providing no claims have been made on the **Plan** and the **Out-Patient Direct Billing** membership card has been returned, in relation to the **Period of Cover** before cancellation (being no more than 14 days' cover). If **You** incur **Eligible** claims costs within that **Period of Cover We** reserve the right to require the **Planholder** to pay for the services **We** have actually provided in connection with the **Plan** to the extent permitted by law and any return of premium is subject to this. If the **Planholder** does not cancel the **Plan** during the cancellation period the **Plan** will continue on the terms described in this handbook for the remainder of the **Period of Cover**.

We may void the Plan for You (as the Insured Person) and Your Dependants in the following situations. If You or Your Dependants:

- Make a misrepresentation by withholding relevant information or giving Us incorrect information
- Make a misrepresentation by making a false or fraudulent claim
- Fail to provide any reasonable information We have asked for
- Fail to pay the premiums due
- If **You** move to the USA, or a country not covered by this **Plan** which may vary from time to time, of which **You** will be advised

- 8.1.8 If You have an Out-Patient Direct Billing membership card, it is Your responsibility to return all such cards for You and Your Dependants to Us if You cancel, or do not renew Your Plan or Your premium payments are not up to date. We will not be liable for any misuse by You of such Out-Patient Direct Billing membership cards, if We have already paid the Benefit We can recover those sums from You.
- **8.1.9** This **Plan** shall be governed by and construed in accordance with the Laws of the UAE and the parties agree to submit to the jurisdiction of the UAE courts.
- 8.1.10 Please ensure that **You** show the following information to others covered under **Your Plan** or make them aware of its contents.

We and the Underwriters will deal with all personal information supplied in the strictest confidence as required by the Personal Data Protection Act. We and Your underwriters collect personal information about You and Your Dependents (including health, bank account and occupation) for the purpose of establishing and administering Your Plan. This includes information supplied by You, those family members, medical providers or Your employer (if applicable). Your information may be passed to Now Health group companies administrating Your Plan, Underwriters, Insurers, Reinsurers, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside Your country of residence. Confidentiality is required of any third parties to whom the administration of Your Plan may be subcontracted, including those based outside the country of Your residency. In certain circumstances, medical service providers (or others) may be asked to supply further information. Your personal details will not be disclosed to other organizations without Your consent.

You have a right of access to, and correction of, information that we hold about You. Please contact Us if You would like to exercise either of these rights. Some of the information We collect about You may be classified as "sensitive" – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain Your explicit consent before We process the information. When You provide information about family members, We will take this as confirmation that You have their consent to do so. As the legal holder of the Plan all correspondence about the plan, including claims correspondence, will be sent to the Planholder. If any family member over 18 insured under the Plan does not want this to happen they should apply for their own Plan.

There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies relating to suspicions of fraudulent claims and other crimes. If required, information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including fraud or otherwise improper claims where there is reasonable suspicion. This may involve adding non-medical information to a database that will be accessible to other insurers and law enforcement agencies. Additionally, the General Medical Council or other relevant regulatory body will be notified about any issue where there is reason to believe a **Medical Practitioner's** fitness to practice may be impaired.

Please contact **Our** Customer Services team or write to **Us** at the address on the back of this handbook if **You** wish Now Health International group companies to contact **You** via letter, SMS or email with details of other IPMI or related product and services. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com/privacy

Your health claims information may be shared by Now Health International Group companies to other Insurance Companies or Reinsurance Companies for the purposes of risk management, contract negotiations, research, development and analysis, as well as, to promote other products that may be of interest to **You**.

8.2 Our rights and responsibilities

- **8.2.1** We will tell the **Planholder** in writing the date the **Plan** starts and any special terms which apply to it. We can refuse to give cover and will tell **You** if **We** do.
- 8.2.2 If for whatever reason there is a break in **Your** cover, **We** may reinstate the cover if the premium is subsequently paid, though terms of cover may be subject to variation. Any acceptance by **Us** is subject to **Our** written consent and **Your** acceptance.
- 8.2.3 We can refuse to add a family member to the Plan and We will tell the Planholder if We do.
- 8.2.4 We will pay for Eligible costs incurred during a period for which the premium has been paid.
- 8.2.5 If You break any of the terms of the Plan which We reasonably consider to be fundamental, We may (subject to 8.2.8) do one or more of the following:
 - Refuse to make any **Benefit** payment or, if **We** have already paid **Benefits**, **We** can recover from **You** any loss to **Us** caused by the break
 - Refuse to renew Your Plan
 - Impose different terms to any cover We are prepared to provide
 - End Your Plan and all cover under it immediately

8.2.6 Break in cover

Where there is a break in cover, for whatever reason, **We** reserve the right to reapply exclusion 5.27 in respect of pre-existing **Medical Conditions**.

- 8.2.7 Waiver by Us of any breach of any term or condition of this **Plan** shall not prevent the subsequent enforcement of that term or condition and shall not be deemed to be a waiver of any subsequent breach.
- 8.2.8 If You (or anyone acting on Your behalf) make a claim under Your Plan knowing it to be false or fraudulent, (i.e. You make a misrepresentation) We can refuse to make Benefit payments for that claim and may declare the Plan void, as if it never existed. If We have already paid the Benefit We can recover those sums from You. Where We have paid a claim later found to be fraudulent, (whether in whole, or in part), We will be able to recover those sums from You.
- 8.2.9 We retain all rights of subrogation. You have no right to admit liability for any event or give any undertaking, which is binding upon You, Your Dependants or any other person named in the Certificate of Insurance without Our prior written consent.
- 8.2.10 We may alter the handbook terms or **Benefit Schedule** from time to time, but no alteration shall take effect until the next annual **Renewal Date**. We shall notify such changes to **You** in writing by sending the details to the primary contact details We have for **You**. We reserve the right to revise or discontinue the **Plan** with effect from any **Renewal Date**. No variation or alteration will be admitted unless it is in writing and signed on behalf of **Us** by an authorised employee.

8.2.11 We will not provide cover nor pay claims under this Plan if Our obligations (or the obligations of Our group companies & administrators) under the laws of any relevant jurisdiction including UAE, UK, European Union, the United States of America, United Nations resolutions, trade or economic sanctions or international laws sanctions, prevents or restricts Us from doing so.

We will not provide You with any services or Benefits including but not limited to acceptance of premium payments, claim payments and other reimbursements if in doing so, We violate applicable law, regulation, code or court order or are or will be otherwise sanctioned, prevented or restricted.

We may terminate Your Plan if We consider You or Your directors or officers as sanctioned persons, or You conduct an activity which is sanctioned, according to trade or economic laws & regulations.

8.2.12 This Plan is written in English and all other information and communications to You relating to this Plan will also be in English unless We have agreed otherwise in writing.



e Insure







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