

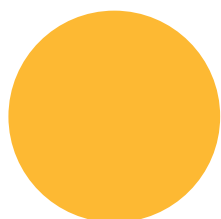
Administered by:



Insured by:



WorldCare Members' Handbook



Companies

Insured by Arabia Insurance Company S.A.L.

Everything you need to know about your international health insurance

Effective 1 April 2026

Introduction

Welcome to **Your** WorldCare **Group Plan**. **Your** company or employer has chosen **Us** to administer **Your** international health insurance **Group 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 Group Plan** works and how to use it. Please read this handbook carefully.

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** WorldCare **Group 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 Group Plan** is administered
- How to make a complaint
- Other services available to **You** under **Your Group 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 Group 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 **Group 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 **Group Plan**, or if **You** would like to tell **Us** about any changes in **Your** personal circumstances, please contact **Us** at:

Arabia Insurance Company S.A.L., c/o Now Health International Gulf Third Party Administrators LLC,
Office No: 1741, Al Ghaith Tower, Aya Business Centers – Branch 1, Hamdan Street, Al Dannah,
Abu Dhabi, United Arab Emirates.

Offices 10, 11 and 12, Block D3, Xavier Business Centre, Level M2, Burj Nahar Mall, Deira,
P.O. Box 334337, Dubai, United Arab Emirates

T +971 (0) 4450 1410 | CustomerService@now-health.com

Contacting Us

While it is important that **You** read and understand this **Group 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.

If **You** have any questions about **Your Group Plan**, **You** can contact **Us** on +971 (0) 4450 1410 or email CustomerService@now-health.com. 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.

If **You** need to let **Us** know about any changes in **Your** personal circumstances, **You** can do so using the contact details above, or write to **Us** at:

Arabia Insurance Company S.A.L., c/o Now Health International Gulf Third Party Administrators LLC,
Office No: 1741, Al Ghaith Tower, Aya Business Centers – Branch 1, Hamdan Street, Al Dannah,
Abu Dhabi, United Arab Emirates.

Offices 10, 11 and 12, Block D3, Xavier Business Centre, Level M2, Burj Nahar Mall, Deira,
P.O. Box 334337, Dubai, United Arab Emirates

Please note that **We** may record and/or monitor calls for quality assurance and training and as a record of **Our** conversation.

Customer service team

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

T +971 (0) 4450 1410

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 1440

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** secure online portfolio at www.now-health.com or contact **Us** via email at ClinicalService@now-health.com.

Contents

1. Definitions	06
2. Manage Your Group Plan online	11
3. How to claim	12
4. Benefits: What is covered?	20
5. Exclusions: What is not covered?	69
6. Group Plan administration	74
7. Making a complaint	76
8. Rights and responsibilities	77

1. Definitions

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

Accident	A sudden, unexpected, unforeseen and involuntary external event resulting in identifiable physical injury occurring to an Insured Person while Your Group 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 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 Group 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 Group 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 Group 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 , Day-Patient and Evacuation or Extended Evacuation expenses incurred before any Benefits are paid under the Group Plan , as specified in Your Certificate of Insurance . The Group 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 Group Plan . In order to determine whether a Treatment or charge is covered, all sections of Your Group Plan should be read together, and are subject to all the terms (including payment of premium due), Benefits and exclusions set out in this Group Plan .
Entry Date	The date shown on the Certificate of Insurance on which an Insured Person was included under this Group Plan . We must have received premium payment in order for Your Benefits to start.
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 Group Plan .

Group Plan	The contract between the Planholder and Us which sets out terms and conditions of the cover provided. The full terms and conditions consist of the Group Employee FMU application form (if applicable), Certificate of Insurance , Benefit Schedule and this members' handbook.
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 Group 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	You and/or the Dependants named on the Certificate of Insurance who are covered under this Group Plan .
Major Elective Surgery	Major Elective Surgery involves complex, invasive procedures on vital organs (head, chest, abdomen, limbs) requiring anesthesia, significant tissue manipulation, a hospital stay, and a longer recovery, carrying higher risks of severe complications or impacting life/major body systems. Eligible Major Elective Surgeries: • Elective Heart Surgeries • Mastectomy with reconstruction • Hip and Knee Joint replacements, Knee ligament repairs & Shoulder surgeries • Brain and spinal surgeries (craniotomies, spinal fusion, Laminectomy, Discectomy, Foraminectomy) • Major vascular surgeries (aortic aneurysm repair, Carotid endarterectomy, Peripheral Vascular bypass, Mesenteric / renal artery reconstruction, Thrombectomy, varicose veins) • Cataract Surgeries
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 Group Plan as specified in Your Certificate of Insurance . Each visit refers to each consultation. The Group 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 Group Plan .
Out-Patient	A patient who attends a Hospital , consulting room, telemedicine appointment or out-patient clinic and is not admitted as a Day-Patient or an In-Patient .
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 medicine in the country where Treatment is provided.
Pre-Authorisation	Means 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 📞 in the Benefit Schedule and as detailed in section 4.
Plan Administrator	The person appointed by the Planholder to administer the Insured Person's Group Plan , and to act as a coordinator with Us .
Planholder	The first Insured Person named on the Certificate of Insurance , or the company.
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 Group 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 .
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.
Traditional Chinese Medicine and Ayurvedic Medicine	Traditional Chinese Medicine (TCM) and Ayurveda Medicine exist outside the institutions where conventional medicine is taught. They are holistic healing systems that focus on the individual rather than the disease. Both systems use a variety of interventions, including herbs, diet, and lifestyle changes.
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 the Entry Date of the Insured Person , during which the Insured Person is 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 Group Plan online

A guide to the secure online portfolio area

The simplest way to manage **Your Group 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 1410.

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 Group Plan** details and download **Your Certificate of Insurance**, members' handbook and claim form from here. **You** can also download **Your** membership card(s) 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 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** join, **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 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 1410 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
- Post to Now Health International Gulf Third Party Administrators LLC, Offices 10, 11 and 12, Block D3, Xavier Business Centre, Level M2, Burj Nahar Mall, Deira, P.O. 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.

- Email to ClaimsService@now-health.com, or
- Post to Now Health International Gulf Third Party Administrators LLC, Offices 10, 11 and 12, Block D3, Xavier Business Centre, Level M2, Burj Nahar Mall, Deira, P.O. 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. **You** may need to allow additional time for banks to process **Your** reimbursement.

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** 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 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 1410 | ClinicalService@now-health.com

Tell **Us** the **Hospital** name, telephone number and 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 Authorisation 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. **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 Group 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 Group 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 1410 | 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** **Group 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 **Group 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 1410 | 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 Group 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 **Group 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 Psychiatry, Alternative Medicine, Hormone replacement therapy and Vitamins and Minerals in addition to dental, maternity and 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 1440 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 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 Group 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 Group 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 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 Group 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 1410 | 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, 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 Group 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 Group 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 Group 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 ask to 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 **Group 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 Benefits** 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 Group 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 Group 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 Group 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 Group 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.

3.12 What is the maximum length of prescription I can claim at one time?

Eligible medications prescribed by **Your Medical Practitioner** will be paid up to 3 months or to the end of **Your** policy date, whichever is the earlier.

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 **Group 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 **Group Plan**.

Please refer to the definition of **Group Plan** in section 1 for details of the documents that make up **Your Group 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 **Group Plan** option 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 Group Plan limits.
Apex	As with Excel, and cover for dental and maternity, as well as Benefits with higher overall limits.

Optional Benefits:

To provide extra flexibility, **You** can also select additional optional **Benefits** that might be important to **You**.

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).
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).
Out-Patient Charges – Option 3 (Essential only)	Adds Accident and Emergency Out-Patient and additional Pre-Operative and Post-Hospitalisation Benefits to the Essential Plan .
Out-Patient Per Visit Excess	This option is available for Advance, Excel and Apex. You can select to pay a USD 25 or USD15 Excess everytime You receive an Out-Patient Consultation . Please note that if You have selected the Out-Patient Per Visit Excess , You must pay the first USD 25 or USD15 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).

Wellness, Optical and Vaccinations	This is an option available on Essential where Out-Patient Charges or Out-Patient Charges – Option 2 has been selected, or on Advance, Excel and Apex Plan . This option allows You to receive limited cover for Wellness, Optical and Vaccinations .
Wellness, Optical and Vaccinations – Option 2	This is an option available on Advance, Excel and Apex Plan . This option allows You to receive limited cover for Wellness, Optical and Vaccinations .
Wellness and Vaccinations – Option 3	This is an option available on Essential where Out-Patient Charges or Out-Patient Charges – Option 2 has been selected, or on Advance, Excel and Apex Plan . This option allows You to receive limited cover for Wellness and Vaccinations .
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.
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 .

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 Group 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 Group 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** 📞”.

You should contact **Our** customer service team on +971 (0) 4450 1410.

Pre-Authorisation means all costs under this **Benefit** require **Pre-Authorisation** from **Us**, which may or may not be included in **Your Group 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, magnetic resonance imaging (MRI) scans, computed tomography (CT) scans
- **In-Patient Psychiatric Treatment**
- **Evacuation and Repatriation**
- Mortal Remains
- Physiotherapy for the Advance, Excel and Apex **Group Plan** options after every 10 sessions
- Nursing Care at home
- AIDS
- USA elective **Treatment**
- **Hospital Cash Benefit (ii)**

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 Group 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 **Group 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 **Group 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)

Benefit	Essential
Annual Maximum Group Plan Limit <i>24/7 helpline and assistance services available on all Group Plans</i>	USD 3m
1. Maintenance of Chronic Medical Conditions: <i>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.</i>	 Not covered
2. Hospital Charges, Medical Practitioner and Specialist Fees: <i>(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.</i> <i>(ii) Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS) when supplied within 6 months of In-Patient or Day-Patient Hospital Treatment for an Eligible Medical Condition, which is prescribed by Your treating Medical Practitioner. We will pay for the following items:</i> i. Purchase or rental of crutches, air boots and initial purchase or rental of a wheelchair (self-propelled) ii. Delivery systems for prescribed drugs and dressings iii. Orthotic supplies such as insoles and orthotic supports iv. External prosthetics required after surgery. These include braces and calipers, initial purchase and fitting of an artificial limb and artificial eyes. Excludes hearing aids.	<i>(i)</i>  Full refund Pre-Authorisation for (i) 📞 <i>(ii)</i>  Up to USD 2,000 per 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, MRI, CT 📞  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: <i>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.</i>	 Full refund
6. Renal Failure and Renal Dialysis: <i>(i) Treatment of renal failure, including renal dialysis on an In-Patient basis.</i> <i>(ii) Treatment of renal failure, including renal dialysis on a Day-Patient or Out-Patient basis.</i>	<i>(i)</i>  Full refund for In-Patient pre and post-operative care <i>(ii)</i>  Up to USD 50,000 per Period of Cover
7. Organ Transplant: <i>(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.</i> <i>(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.</i> 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>(i)</i>  Full refund <i>(ii)</i>  Up to USD 50,000 per Period of Cover
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	Essential
9. Pregnancy Medical Conditions: <i>In-Patient Treatment</i> of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. We would only allow Treatment of the following as an Eligible Medical Condition under this Benefit: • 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 This benefit does not provide any cover for voluntary or Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. Waiting Period: Costs Incurred within 12 months from the Start Date of the mother are excluded.	 Full refund
10. New Born Cover: <i>In-Patient Treatment</i> 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 100,000 per Period of Cover
11. Hospital Accommodation for New Born Accompanying their Mother: <i>Hospital Accommodation</i> 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: <i>In-Patient Treatment</i> 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 100,000 per Period of Cover
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: - Use of special Treatment rooms - Physical therapy fees - Speech therapy fees - Occupational therapy fees	 Full refund for Eligible In-Patient Treatment only up to 30 days per Medical Condition
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

Benefit	Essential
16. In-Patient Psychiatric Treatment: <i>In-Patient Treatment</i> 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 Cover
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.	▶ Eligible In-Patient and Day-Patient Treatment only up to USD 50,000 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 Medical Conditions are specifically excluded from this Benefit.	▶ Accident: Full refund for Accident requiring In-Patient and 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: 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 (including air ambulance if required) 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 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 Following an Evacuation covered by Us, 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. We do not cover standalone repatriation. Charges relating to routine Pregnancy and Pregnancy Medical Conditions are specifically excluded from this Benefit.	Pre-Authorisation 📄 (i) ▶ Full refund (ii) ▶ Full refund (iii) ▶ Full refund (iv) ▶ Up to USD 200 per day Up to USD 7,500 per person, per Evacuation Pre-Authorisation 📄 ▶ Full refund

Benefit	Essential
20. Mortal Remains: <i>In the event of death from an Eligible Medical Condition, Reasonable and Customary Charges for:</i> (i) <i>Costs of transportation of body or ashes of an Insured Person to his/her Country of Nationality or Country of Residence, or</i> (ii) <i>Burial or cremation costs at the place of death in accordance with reasonable and customary practice.</i>	Pre-Authorisation 📞 (i)  Full refund (ii)  Up to USD 10,000
21. Hospital Cash Benefit: i) <i>This Benefit is payable when 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.</i> <i>This Benefit is not payable if the Insured Person is Eligible for Hospital Cash Benefit ii) Major Elective Surgery. This Benefit is limited to a minimum of 30 days between Eligible admissions, and up to a maximum of 5 admissions per policy year.</i> ii) <i>This Benefit is payable when an Insured Person undergoes Major Elective Surgery 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.</i> <i>This Benefit is subject to pre-approval and subject to a minimum of 30 days between Eligible admissions, and up to a maximum of 3 admissions per policy year.</i> <i>For this Benefit exclusion 5.10 does not apply. This Benefit is not payable if your admission and this Benefit is not pre-approved. This Benefit is not Eligible if You are admitted for an Accident and Emergency.</i> Waiting Period: Cover only available after nine months of continuous membership.	Pre-Authorisation 📞  i) Up to USD 200 per admission ii) Up to USD 1,000 per Major Elective Surgery
22. Out-Patient Charges: (i) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. (ii) Teleconsultation (Virtual Doctor appointments via electronic means). Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the Now Health International Provider Network. Treatment that is not received in the Now Health International Provider Network will pay Reasonable and Customary Charges. No Out-Patient Co-Insurance or Out Patient visit Excess is applicable. (iii) Vitamins and Minerals: Vitamins and Minerals as prescribed by a Medical Practitioner. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the Out-Patient Benefit. Any pre-operative and post-hospitalisation consultations are payable under this Benefit.	(i) and (ii)  Pre-operative consultation within 15 days from the admission and post hospitalisation consultation within 30 days following discharge from Hospital Up to maximum USD 2,000 per Medical Condition per Period of Cover (iii)  Not covered
23. Menopause Hormone Replacement Therapy: <i>The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and Treatment commence below the age of 40 years.</i>	 Not covered
24. Day-Patient or Out-Patient Surgery: <i>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.</i>	 Full refund
25. Out Patient Psychiatric Illness: <i>Out-Patient Treatment administered by a Registered Psychologist and/or a Registered Psychiatrist, subject to 10 sessions and the cost limit under this section.</i> <i>For the first 5 sessions You may choose to visit a Registered Psychologist directly without the need for referral. However, any subsequent sessions with a Registered Psychologist will require referral and a Treatment Plan with a Medical Practitioner or Specialist.</i>	 Not covered

Benefit	Essential
26. Out-Patient Physiotherapy and Alternative Therapies: (i) Physiotherapy by a Registered Physiotherapist. (ii) Complementary medicine and Treatment by a therapist. This Benefit extends to osteopaths, chiropodists and podiatrists, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). You may choose 5 sessions for any combination of Benefits in aggregate in a given Period of Cover for Benefits (i) and (ii) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist. Please note that sessions must be conducted at a recognised medical facility or an approved healthcare center. Home-based sessions are not covered.	(i)  Up to 5 sessions within 30 days after hospitalisation. (ii)  Not covered
27. Out-Patient Traditional Chinese Medicine and Ayurvedic Medicine: Out-Patient Treatment for therapies administered by a recognised Traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. All claims to include diagnosis, consultation fee, Treatment type, Treatment fee, prescription including detailed medication and number of doses. Exclusion 5.35 applies.	 Not covered
28. 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.	Pre-Authorisation 📞 (i)  Up to USD 100 per day, up to 30 days per Medical Condition (ii)  Not covered
29. 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; and a positive HIV test occurred within 12 months of the reported occupational Accident. ** 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-Authorisation 📞  Eligible In-Patient and Day-Patient Treatment only up to USD 25,000 per Period of Cover

Options to Core Benefits

Essential

30. 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 (twice per year),
 - Fillings (standard amalgam or composite fillings) and extractions,
 - Root-canal **Treatment** (but not the fitting of a crown following root-canal **Treatment**), and
 - Prescribed **Drugs and Dressings**.

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.

- (ii) **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, inlays 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; Dental implant; and prescribed **Drugs and Dressings**.

No other **Treatment** (including Orthodontics) is covered by this **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.

Please note that this **Benefit** is only available when **Out-Patient Charges** or **Out-Patient Charges Option 2 (Benefit 321 or 33)** are selected.

(i)  Optional
Up to USD 250
per **Period of Cover**

(ii)  Optional
Up to USD 1,000
per **Period of Cover**

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 up to **Your Out-Patient Benefit** limit.

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

This option is not available if **You** have selected an optional **Regional Cover**.

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**

Options to Core Benefits

Essential

32. Out-Patient Charges:

- (i) **Medical Practitioner** fees including consultation, **Specialist** fees, **Diagnostic Tests**, prescribed **Drugs and Dressings**.
- (ii) Teleconsultation (Virtual Doctor appointments via electronic means).
Costs associated with **Eligible Treatment** will be paid in full where **Treatment** is received from **Medical Providers** listed in the **Now Health International Provider Network**.
Treatment that is not received in the **Now Health International Provider Network** will pay **Reasonable and Customary Charges**.
No **Out-Patient Co-Insurance** or **Out Patient visit Excess** is applicable.

- (iii) **Vitamins and Minerals**:
Vitamins and Minerals as prescribed by a **Medical Practitioner**. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the **Out-Patient Benefit**.

This **Benefit** (i), (ii) and (iii) replaces **Benefit 22 – Out-Patient Charges**.

- (iv) a. Physiotherapy by a Registered **Physiotherapist**.
b. Complementary medicine and **Treatment** by a therapist. This **Benefit** extends to osteopaths, chiropodists and podiatrists, 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**. All claims to include diagnosis, consultation fee, **Treatment** type, **Treatment** fee, prescription including detailed medication and number of doses.

You may choose 5 sessions for any combination of **Benefits** in aggregate in a given **Period of Cover** for **Benefits** (iv)a. and (iv)b. excluding dietician without the need of referral; any subsequent sessions need to be referred by a **Medical Practitioner** or **Specialist**.

This **Benefit** replaces **Benefit 26 – Out-Patient Physiotherapy and Alternative Therapies**.

Any pre-operative and post-hospitalisation consultations are payable under this **Benefit**.

Please note that sessions must be conducted at a recognised medical facility or an approved healthcare center. Home-based sessions are not covered.

- (v) **Out Patient Psychiatric Illness**:

Out-Patient Treatment administered by a Registered Psychologist and/or a Registered Psychiatrist, subject to 10 sessions and the cost limit under this section.

For the first 5 sessions **You** may choose to visit a Registered Psychologist directly without the need for referral. However, any subsequent sessions with a Registered Psychologist will require referral and a **Treatment Plan** with a **Medical Practitioner** or **Specialist**.

This **Benefit** replaces **Benefit 25 – Out-Patient psychiatric illness**.

- (vi) **Menopause Hormone Replacement Therapy**:

The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and **Treatment** commence below the age of 40 years.

This **Benefit** replaces **Benefit 23 – Menopause Hormone Replacement Therapy**.

Please note that if this option is chosen, the only **Plan Deductible** options that can be chosen are USD 150, USD 250, USD 500, 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.

- (i) and (ii) 

Optional
Up to USD 5,000
per **Period of Cover**
in aggregate

- (iii) 

Optional
Up to USD 150
per **Period of Cover**
in aggregate of
overall **Out-Patient**
Charges **Benefit** limit

Combined
Out-Patient Charges
Benefit limit
Up to USD 5,000
per **Period of Cover**
for (i), (ii) & (iii)

- (iv) 

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 26

- (v) 

Optional
Up to USD 500
and a maximum of
10 sessions per
Period of Cover in
aggregate

- (vi) 

Optional
Up to USD 400
per **Period of Cover**

Options to Core Benefits

Essential

33. Out-Patient Charges Option 2:

Out-Patient Charges including costs associated with maintenance of chronic **Medical Conditions**.

- (i) **Medical Practitioner** fees including consultation, **Specialist** fees, **Diagnostic Tests**, prescribed **Drugs and Dressings**.
- (ii) Teleconsultation (Virtual Doctor appointments via electronic means).
Costs associated with **Eligible Treatment** will be paid in full where **Treatment** is received from **Medical Providers** listed in the **Now Health International Provider Network**. **Treatment** that is not received in the **Now Health International Provider Network** will pay **Reasonable and Customary Charges**.
No **Out-Patient Co-Insurance** or **Out Patient visit Excess** is applicable.
- (iii) **Vitamins and Minerals**:
Vitamins and Minerals as prescribed by a **Medical Practitioner**. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the **Out-Patient Benefit**.

This **Benefit** (i), (ii) and (iii) replaces **Benefit 22 – Out-Patient Charges**.

- (iv) a. Physiotherapy by a Registered **Physiotherapist**.
- b. Complementary medicine and **Treatment** by a therapist. This **Benefit** extends to osteopaths, chiropodists and podiatrists, 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**. All claims to include diagnosis, consultation fee, **Treatment** type, **Treatment** fee, prescription including detailed medication and number of doses.

You may choose 5 sessions for any combination of **Benefits** in aggregate in a given **Period of Cover** for **Benefits** (iv)a. and (iv)b. excluding dietician without the need of referral; any subsequent sessions need to be referred by a **Medical Practitioner** or **Specialist**.

This **Benefit** replaces **Benefit 26 – Out-Patient Physiotherapy and Alternative Therapies**.

Any pre-operative and post-hospitalisation consultations are payable under this **Benefit**.

Please note that sessions must be conducted at a recognised medical facility or an approved healthcare center. Home-based sessions are not covered.

- (v) **Out Patient Psychiatric Illness**:
Out-Patient Treatment administered by a Registered Psychologist and/or a Registered Psychiatrist, subject to 10 sessions and the cost limit under this section.
For the first 5 sessions You may choose to visit a Registered Psychologist directly without the need for referral. However, any subsequent sessions with a Registered Psychologist will require referral and a **Treatment Plan** with a **Medical Practitioner** or **Specialist**.

This **Benefit** replaces **Benefit 25 – Out-Patient psychiatric illness**.

- (vi) **Menopause Hormone Replacement Therapy**:
The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and **Treatment** commence below the age of 40 years.

This **Benefit** replaces **Benefit 23 – Menopause Hormone Replacement Therapy**.

Please note that if this option is chosen, the only **Plan Deductible** options that can be chosen are USD 150, USD 250, USD 500, 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.

(i) and (ii) 
Optional
Up to USD 5,000
per **Period of Cover**
in aggregate

(iii) 
Optional
Up to USD 150
per **Period of Cover**
in aggregate of
overall **Out-Patient**
Charges **Benefit** limit

Combined
Out-Patient Charges
Benefit limit
Up to USD 5,000
per **Period of Cover**
for (i), (ii) & (iii)

(iv) 
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 26

(v) 
Optional
Up to USD 500
and a maximum of
10 sessions per
Period of Cover in
aggregate

(vi) 
Optional
Up to USD 400
per **Period of Cover**

Options to Core Benefits	Essential
34. Out-Patient Charges Option 3: (i) Emergency Out-Patient Benefit: Charges for Emergency Treatment received as an Out-Patient in the Accident and Emergency department of a medical provider including: Medical Practitioner fees including consultation; Specialist fees; Diagnostic Tests, prescribed Drugs and Dressings. (ii) Pre and Post-Operative Out-Patient Charges: a. Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. b. Teleconsultation (Virtual Doctor appointments via electronic means). Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the Now Health International Provider Network. Treatment that is not received in the Now Health International Provider Network will pay Reasonable and Customary Charges. c. Physiotherapy by a Registered Physiotherapist. Any pre-operative and post-hospitalisation consultations are payable under this Benefit. Charges relating to pre-operative consultation within 60 days from the admission and post-hospitalisation consultation within 90 days following discharge from Hospital. This Benefit replaces Benefit 22- Out-Patient Charges and Benefit 26 – Out-Patient Physiotherapy and Alternative Therapies. Please note that sessions must be conducted at a recognised medical facility or an approved healthcare center. Home-based sessions are not covered.	(i)  Optional Up to a maximum USD 300 per Period of Cover in aggregate and subject to USD 25 Out-Patient Per Visit Excess (ii)  Optional Up to a maximum USD 3,500 per Medical Condition per Period of Cover Physiotherapy is up to 5 sessions within 90 days following hospitalisation in aggregate.
35. Co-Insurance Out-Patient Treatment: A 10% Co-Insurance will apply to all Eligible Out-Patient Treatment. Should Your Group 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.	 Optional
36. Co-Insurance Out-Patient Treatment Option 2: A 20% Co-Insurance will apply to all Eligible Out-Patient Treatment. Should Your Group 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.	 Optional
37. Medical History Disregarded: Please note that the Waiting Period does not apply to the Pregnancy Medical Conditions or Hospital Cash (ii) Benefits, if Medical History Disregarded is selected.	 Optional For Compulsory Group Plans 10+ employees

Additional Options for Group Plans

Essential

38. Wellness, Optical and Vaccinations:

- (i) **Wellness:** This **Benefit** is payable as a contribution towards the cost of routine health checks including **Cancer** screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital sign (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age). and/or
- (ii) **Optical Benefits:** This **Benefit** also provides a contribution towards optician charges including an annual eye test carried out by an Ophthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, and Laser Eye Surgery and any complications, 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
- (iii) **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.

This **Benefit** can only be taken on WorldCare Essential if **You** select an optional **Out-Patient Charges** or **Out-Patient Charges** – Option 2.

 Optional

 Combined limit
Up to USD 500
per **Period of Cover**

39. Wellness and Vaccinations Option 3:

- (i) **Wellness:** This **Benefit** is payable as a contribution towards the cost of routine health checks including **Cancer** screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age). and/or
- (ii) **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.

This **Benefit** can only be taken on WorldCare Essential if **You** select an optional **Out-Patient Charges** or **Out-Patient Charges** – Option 2.

 Optional

 Combined limit
Up to USD 250
per **Period of Cover**

40. 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 (including air ambulance if required) 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

Following an **Evacuation** covered by **Us**, 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.

We do not cover standalone repatriation.

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

Pre-Authorisation 

(i)  Full refund

(ii)  Full refund

(iii)  Full refund

(iv)  Up to USD 200
per day
Up to USD 7,500
per person,
per **Evacuation**

Pre-Authorisation 

 Full refund

Deductible Options	Essential
Standard Deductible	Nil
Optional Deductible:	USD 150
	USD 250
	USD 500
	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.

4.3.2 WorldCare Advance

Benefit	Advance
Annual Maximum Group Plan Limit 24/7 helpline and assistance services available on all Group 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
2. Hospital Charges, Medical Practitioner and Specialist Fees: (ii) 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) Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS) when supplied within 6 months of In-Patient or Day-Patient Hospital Treatment for an Eligible Medical Condition , which is prescribed by Your treating Medical Practitioner . We will pay for the following items: i. Purchase or rental of crutches, air boots and initial purchase or rental of a wheelchair (self-propelled) ii. Delivery systems for prescribed drugs and dressings iii. Orthotic supplies such as insoles and orthotic supports iv. External prosthetics required after surgery. These include braces and calipers, initial purchase and fitting of an artificial limb and artificial eyes. Excludes hearing aids.	(ii)  Full refund Pre-Authorisation for (i) 📄 (ii)  Up to USD 2,000 per 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, MRI, CT 📄  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) 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 (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
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	Advance
9. Pregnancy Medical Conditionss: <i>In-Patient Treatment</i> of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. We would only allow Treatment of the following as an Eligible Medical Condition under this Benefit: • 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 This benefit does not provide any cover for voluntary or Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. Waiting Period: Costs Incurred within 12 months from the Start Date of the mother are excluded.	Full refund
10. New Born Cover: <i>In-Patient Treatment</i> 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 100,000 per Period of Cover
11. Hospital Accommodation for New Born Accompanying their Mother: <i>Hospital Accommodation</i> 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: <i>In-Patient Treatment</i> 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 100,000 per Period of Cover
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 per Medical Condition
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

Benefit	Advance
16. In-Patient Psychiatric Treatment: <i>In-Patient Treatment</i> 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 Cover
17. Terminal Illness: <i>Palliative and Hospice Care:</i> 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 50,000 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 Medical Conditions are specifically excluded from this Benefit.	▶ Accident: Full refund for Accident requiring In-Patient and 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: 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 (including air ambulance if required) 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 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 Following an Evacuation covered by Us, 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. We do not cover standalone repatriation. Charges relating to routine Pregnancy and Pregnancy Medical Conditions are specifically excluded from this Benefit.	Pre-Authorisation 📞 (i) ▶ Full refund (ii) ▶ Full refund (iii) ▶ Full refund (iv) ▶ Up to USD 200 per day Up to USD 7,500 per person, per Evacuation Pre-Authorisation 📞 ▶ Full refund
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, (ii) Burial or cremation costs at the place of death in accordance with reasonable and customary practice.	Pre-Authorisation 📞 (i) ▶ Full refund (ii) ▶ Up to USD 10,000

Benefit	Advance
21. Hospital Cash Benefit: i) This Benefit is payable when 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. This Benefit is not payable if the Insured Person is Eligible for Hospital Cash Benefit ii) Major Elective Surgery. This Benefit is limited to a minimum of 30 days between Eligible admissions, and up to a maximum of 5 admissions per policy year. ii) This Benefit is payable when an Insured Person undergoes Major Elective Surgery 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. This Benefit is subject to pre-approval and subject to a minimum of 30 days between Eligible admissions, and up to a maximum of 3 admissions per policy year. For this Benefit exclusion 5.10 does not apply. This Benefit is not payable if your admission and this Benefit is not pre-approved. This Benefit is not Eligible if You are admitted for an Accident and Emergency. Waiting Period: Cover only available after nine months of continuous membership.	Pre-Authorisation 📄 ▶ i) Up to USD 200 per admission ii) Up to USD 1,000 per Major Elective Surgery
22. Out-Patient Charges: (i) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. (ii) Teleconsultation (Virtual Doctor appointments via electronic means). Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the Now Health International Provider Network. Treatment that is not received in the Now Health International Provider Network will pay Reasonable and Customary Charges. No Out-Patient Co-Insurance or Out Patient visit Excess is applicable. (iii) Vitamins and Minerals: Vitamins and Minerals as prescribed by a Medical Practitioner. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the Out-Patient Benefit. Any pre-operative and post-hospitalisation consultations are payable under this Benefit.	(i) and (ii) ▶ Full refund (iii) ▶ Up to USD 150 per Period of Cover
23. Menopause Hormone Replacement Therapy: The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and Treatment commence below the age of 40 years.	▶ Up to USD 500 per Period of Cover
24. 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
25. Out-Patient Psychiatric Illness: Out-Patient Treatment administered by a Registered Psychologist and/or a Registered Psychiatrist, subject to 10 sessions and the cost limit under this section. For the first 5 sessions You may choose to visit a Registered Psychologist directly without the need for referral. However, any subsequent sessions with a Registered Psychologist will require referral and a Treatment Plan with a Medical Practitioner or Specialist.	▶ Up to USD 2,500 and subject to a maximum of 10 sessions per Period of Cover
26. Out-Patient Physiotherapy and Alternative Therapies: (i) Physiotherapy by a Registered Physiotherapist. (ii) Complementary medicine and Treatment by a therapist. This Benefit extends to osteopaths, chiropodists and podiatrists, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). You may choose 5 sessions for any combination of Benefits in aggregate in a given Period of Cover for Benefits (i) and (ii) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist. Please note that sessions must be conducted at a recognized medical facility or an approved healthcare centre. Home-based sessions are not covered.	(i) ▶ Full refund up to a maximum of 30 sessions per Period of Cover (ii) ▶ Full refund up to a maximum of 30 visits per Period of Cover Pre-Authorisation for (i) and (ii) after every 10 visits 📄

Benefit	Advance
27. Out-Patient Traditional Chinese Medicine and Ayurvedic Medicine: Out-Patient Treatment for therapies administered by a recognised Traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. All claims to include diagnosis, consultation fee, Treatment type, Treatment fee, prescription including detailed medication and number of doses. Exclusion 5.35 applies.	 Up to USD 1,000 per Period of Cover
28. 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 per Medical Condition Pre-Authorisation for (i)  (ii)  Not Covered
29. 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; and a positive HIV test occurred within 12 months of the reported occupational Accident. ** 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-Authorisation   Up to USD 25,000 per Period of Cover

Benefit

Advance

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 (AED 100) per night.
 - (vi) Essential **Vaccinations** and inoculations for newborns and children as stipulated in the DHA policies and its updates, in assigned facilities covered up to a limit of USD 28 (AED 100).
 - (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 gynaecology 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 and checks and tests in accordance with the DHA antenatal Protocols. Initial investigations 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 2,750 for normal Pregnancy and USD 2,750 for C-section per **Insured Person**, per **Period of Cover**.
- 10% **Co-Insurance** payable by the Insured for all **Out-Patient** and **In-Patient** maternity services.
- (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).
 - (xi) Psychiatry and Mental Health: Outpatient counselling covered up to USD 218 (AED 800) per year subject to a 30% coinsurance payable by the insured per visit.
 - (xii) Influenza Vaccine covered once a year. Unless otherwise indicated these Benefits will not be payable for **Treatment** outside the United Arab Emirates.
 - (xiii) Organ transplantation: Coverage up to limit of USD 27,226 (AED 100,000) for recipient only. 20% coinsurance payable by the insured per visit for outpatient visits.
 - (xiv) Dialysis: Covered to a limit of USD 16,336 (AED 60,000). 20% coinsurance payable by the insured per visit for outpatient visits.
 - (xv) Dental Benefits: Dental consultation, extraction, fillings, root canal treatment, scaling, x-rays, antibiotics and prophylaxis covered up to USD 137 (AED 500). 30% coinsurance payable by the insured per visit for outpatient visits. No coinsurance applicable if a follow-up visit is made within 7 days.
 - (xvi) Repatriation costs for the transport of mortal remains to the country of origin: Coverage up to limit of USD 1,362 (AED 5,000)
 - (xvii) Hearing and vision aids, and vision correction by surgeries and laser: Excluded healthcare services except in cases of medical emergencies. Subject to 20% coinsurance.

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.

****Note:** Above mentioned benefits are the minimum required DHA benefits however if client has opted for the upgraded plan (enhanced benefits) he/she will avail the benefits under the enhanced coverage.

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.

Benefit

Advance

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 concerning the Regulations of Work Relations, as amended and applicable laws in this respect.

Options to Core Benefits	Advance
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 up to Your Out-Patient Benefit limit. In-Patient and Day-Patient Treatment that is not received in the Now Health International Provider Network will be subject to a 50% Co-Insurance. This option is not available if You have selected an optional Regional Cover.	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
33. 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, 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.	Optional
34. 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, 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.	Optional
35. 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 one of the Out-Patient Per Visit Excess options or one of the Co-Insurance Plan options, these will still apply in the Restricted Network.	Optional
36. Wellness, Optical and Vaccinations: (i) Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age). and/or (ii) Optical Benefits: This Benefit also provides a contribution towards optician charges including an annual eye test carried out by an Ophthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, and Laser Eye Surgery and any complications, 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 (iii) 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.	Optional For Compulsory Group Plans 3+ employees Combined limit Up to USD 500 per Period of Cover

Options to Core Benefits	Advance
37. Wellness, Optical and Vaccinations Option 2: (i) Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age). and/or (ii) Optical Benefits: This Benefit also provides a contribution towards optician charges including an annual eye test carried out by an Ophthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, and Laser Eye Surgery and any complications, within the combined Benefit limits to a maximum USD 600 per Period of Cover for an optical claim. Please note that there is no cover for prescription sunglasses or transition lenses. and/or (iii) 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.	 Optional For Compulsory Group Plans 3+ employees  Combined limit Up to USD 1,000 per Period of Cover
38. Wellness and Vaccinations Option 3: (i) Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age). and/or (ii) 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.	 Optional  Combined limit Up to USD 250 per Period of Cover
39. Medical History Disregarded: Please note that the Waiting Period does not apply to either the Pregnancy Medical Conditions, Maternity, Dental Care or Hospital Cash (ii) Benefits, if Medical History Disregarded is selected.	 For Compulsory Group Plans 10+ employees
40. 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, – Preventative scaling, polishing, and sealing (twice per year), – Fillings (standard amalgams or composite fillings) and extractions, – Root-canal Treatment (but not fitting of a crown following root-canal Treatment), and – Prescribed Drugs and Dressings. No other Treatment is covered under the routine dental Treatment Benefit. Waiting Period: Costs incurred within nine months from the Entry Date are excluded. A Co-Insurance of 20% applies. For this Benefit the Group Plan Deductible or Group Plan Out-Patient Per Visit Excess does not apply. (ii) 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; Dental implant; and prescribed Drugs and Dressings. No other Treatment is covered under this Benefit. Waiting Period: Costs incurred within nine months from the Entry Date are excluded. A Co-Insurance of 20% applies. A 50% Co-Insurance applies in respect of all orthodontic Treatment. For this Benefit the Group Plan Deductible or Group Plan Out-Patient Per Visit Excess does not apply.	 Optional For Compulsory Group Plans 10+ employees  (i) Up to USD 500 per Period of Cover  (ii) Up to USD 1,000 per Period of Cover

Additional Options for Group Plans

Advance

41. Maternity (No Co-Insurance):

Medically Necessary costs incurred during **Pregnancy** and childbirth for pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary or emergency 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.

Claims for any caesarean sections are only recoverable from us if you have a maternity **Benefit** as part of your policy. They are not covered by any other **Benefit**.

The **Group Plan Deductible** applies to this **Benefit**.

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



Optional
For Compulsory
Group Plans
10+ employees



Up to USD 8,500 limit
per **Period of Cover**

42. Maternity (10% Co-Insurance):

Medically Necessary costs incurred during **Pregnancy** and childbirth for pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary or emergency 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.

A **Co-Insurance** of 10% applies.

Please note, **We** do not pay for parenting or other teaching classes as these are a matter of personal choice.

Claims for any caesarean sections are only recoverable from us if you have a maternity **Benefit** as part of your policy. They are not covered by any other **Benefit**.

The **Group Plan Deductible** applies to this **Benefit**.

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



Optional
For Compulsory
Group Plans
10+ employees



Up to USD 8,500 limit
per **Period of Cover**

43. Removal of Dental Co-Insurance:

No **Co-Insurance** will be applied to Dental Care.



Optional
For Compulsory
Group Plans
10+ employees

Additional Options for Group Plans	Advance
44. 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 (including air ambulance if required) 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 Following an Evacuation covered by Us, 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. We do not cover standalone repatriation. Charges relating to routine Pregnancy and Pregnancy Medical Conditions are specifically excluded from this Benefit.	Pre-Authorisation 📞 Optional (i) Full refund (ii) Full refund (iii) Full refund (iv) Up to USD 200 per day Up to USD 7,500 per person, per Evacuation Pre-Authorisation 📞 Full refund
Out-Patient Per Visit Excess Options 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: If Your Group Plan also includes Dental care Benefit, as detailed in Your Benefit Schedule, no Out-Patient Per Visit Excess will be applicable. Please note that the Out-Patient Per Visit Excess will not apply to Consultation relating to Renal dialysis/Renal failure, Cancer or Organ Transplants. 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. Please note: If Your Group Plan also includes Dental care Benefit, as detailed in Your Benefit Schedule, no Out-Patient Per Visit Excess will be applicable. Please note that the Out-Patient Per Visit Excess will not apply to Consultation relating to Renal dialysis/Renal failure, Cancer or Organ Transplants.	Advance Optional USD 25 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.	

Deductible Options	Advance
Standard Deductible	<i>Nil</i>
Optional Deductible:	<i>USD 150</i>
	<i>USD 250</i>
	<i>USD 500</i>
<i>Please note:</i>	<i>USD 1,000</i>
<i>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.</i>	<i>USD 2,500</i>
<i>Deductibles would apply to any Medically Necessary Treatment required under Benefit 19 and Benefit 44.</i>	<i>USD 5,000</i>
	<i>USD 10,000</i>
	<i>USD 15,000</i>

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

4.3.3 WorldCare Excel

Benefit	Excel
Annual Maximum Group Plan Limit 24/7 helpline and assistance services available on all Group Plans	USD 4m
1. Maintenance of Chronic Medical Conditions: <i>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.</i>	 Full refund
2. Hospital Charges, Medical Practitioner and Specialist Fees: <i>(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.</i> <i>(ii) Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS) when supplied within 6 months of In-Patient or Day-Patient Hospital Treatment for an Eligible Medical Condition, which is prescribed by Your treating Medical Practitioner. We will pay for the following items:</i> i. Purchase or rental of crutches, air boots and initial purchase or rental of a wheelchair (self-propelled) ii. Delivery systems for prescribed drugs and dressings iii. Orthotic supplies such as insoles and orthotic supports iv. External prosthetics required after surgery. These include braces and calipers, initial purchase and fitting of an artificial limb and artificial eyes. Excludes hearing aids.	<i>(i)</i>  Full refund Pre-Authorisation for (i) 📄 <i>(ii)</i>  Up to USD 3,000 per 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, MRI, CT 📄  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) Treatment of renal failure, including renal dialysis on an In-Patient basis.</i> <i>(ii) Treatment of renal failure, including renal dialysis on a Day-Patient or Out-Patient basis.</i>	<i>(i)</i>  Full refund <i>(ii)</i>  Up to USD 100,000 per Period of Cover
7. Organ Transplant: <i>(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.</i> <i>(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.</i> 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>(i)</i>  Full refund <i>(ii)</i>  Up to USD 50,000 per Period of Cover
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 Medical Conditions: <i>In-Patient Treatment</i> of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. We would only allow Treatment of the following as an Eligible Medical Condition under this Benefit: • 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 This benefit does not provide any cover for voluntary or Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. Waiting Period: Costs Incurred within 12 months from the Start Date of the mother are excluded.	Full refund
10. New Born Cover: <i>In-Patient Treatment</i> 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 Period of Cover
11. Hospital Accommodation for New Born Accompanying their Mother: <i>Hospital Accommodation</i> 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: <i>In-Patient Treatment</i> 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 Cover
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

Benefit	Excel
16. In-Patient Psychiatric Treatment: <i>In-Patient Treatment</i> 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 Cover
17. Terminal Illness: <i>Palliative and Hospice Care:</i> 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 Medical Conditions are specifically excluded from this Benefit.	▶ Accident: Full refund for Accident requiring In-Patient and Day-Patient care ▶ Illness: In-Patient and Day-Patient care up to USD 35,000 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: 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 (including air ambulance if required) 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 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 Following an Evacuation covered by Us, 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. We do not cover standalone repatriation. Charges relating to routine Pregnancy and Pregnancy Medical Conditions are specifically excluded from this Benefit.	Pre-Authorisation 📄 (i) ▶ Full refund (ii) ▶ Full refund (iii) ▶ Full refund (iv) ▶ Up to USD 200 per day Up to USD 7,500 per person, per Evacuation Pre-Authorisation 📄 ▶ Full refund
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 (ii) Burial or cremation costs at the place of death in accordance with reasonable and customary practice.	Pre-Authorisation 📄 (i) ▶ Full refund (ii) ▶ Up to USD 15,000

Benefit	Excel
21. Hospital Cash Benefit: i) This Benefit is payable when 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. This Benefit is not payable if the Insured Person is Eligible for Hospital Cash Benefit ii) Major Elective Surgery. This Benefit is limited to a minimum of 30 days between Eligible admissions, and up to a maximum of 5 admissions per policy year. ii) This Benefit is payable when an Insured Person undergoes Major Elective Surgery 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. This Benefit is subject to pre-approval and subject to a minimum of 30 days between Eligible admissions, and up to a maximum of 3 admissions per policy year. For this Benefit exclusion 5.10 does not apply. This Benefit is not payable if your admission and this Benefit is not pre-approved. This Benefit is not Eligible if You are admitted for an Accident and Emergency. Waiting Period: Cover only available after nine months of continuous membership.	Pre-Authorisation 📄 ▶ i) Up to USD 200 per admission ii) Up to USD 1,000 per Major Elective Surgery
22. Out-Patient Charges: (i) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. (ii) Teleconsultation (Virtual Doctor appointments via electronic means). Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the Now Health International Provider Network. Treatment that is not received in the Now Health International Provider Network will pay Reasonable and Customary Charges. No Out-Patient Co-Insurance or Out Patient visit Excess is applicable. (iii) Vitamins and Minerals: Vitamins and Minerals as prescribed by a Medical Practitioner. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the Out-Patient Benefit. Any pre-operative and post-hospitalisation consultations are payable under this Benefit.	(i) and (ii) ▶ Full refund (iii) ▶ Up to USD 150 per Period of Cover
23. Menopause Hormone Replacement Therapy: The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and Treatment commence below the age of 40 years.	▶ Up to USD 600 per Period of Cover
24. 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
25. Out Patient Psychiatric Illness: Out-Patient Treatment administered by a Registered Psychologist and/or a Registered Psychiatrist, subject to 15 sessions and the cost limit under this section. For the first 5 sessions You may choose to visit a Registered Psychologist directly without the need for referral. However, any subsequent sessions with a Registered Psychologist will require referral and a Treatment Plan with a Medical Practitioner or Specialist.	▶ Up to USD 5,000 and subject to a maximum of 15 sessions per Period of Cover
26. Out-Patient Physiotherapy and Alternative Therapies: (i) Physiotherapy by a Registered Physiotherapist. (ii) Complementary medicine and Treatment by a therapist. This Benefit extends to osteopaths, chiropodists and podiatrists, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). You may choose 5 sessions for any combination of Benefits in aggregate in a given Period of Cover for Benefits (i) and (ii) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist. Please note that sessions must be conducted at a recognised medical facility or an approved healthcare center. Home-based sessions are not covered.	(i) ▶ Full refund (ii) ▶ Full refund Pre-Authorisation for (i) and (ii) after every 10 sessions 📄

Benefit	Excel
27. Out-Patient Traditional Chinese Medicine and Ayurvedic Medicine: Out-Patient Treatment for therapies administered by a recognised Traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. All claims to include diagnosis, consultation fee, Treatment type, Treatment fee, prescription including detailed medication and number of doses. Exclusion 5.35 applies.	Up to USD 1,500 per Period of Cover
28. 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 per Medical Condition Pre-Authorisation for (i)  (ii) Not covered 
29. 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; and a positive HIV test occurred within 12 months of the reported occupational Accident. ** 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-Authorisation  Up to USD 40,000 per Period of Cover
30. 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 (twice per year), – Fillings (standard amalgam or composite fillings) and extractions, – Root-canal Treatment (but not the fitting of a crown following root-canal Treatment), and – Prescribed Drugs and Dressings. No other Treatment is covered under the routine dental Treatment Benefit. Waiting Period: Costs incurred within nine months from the Entry Date are excluded. A Co-Insurance of 20% applies. For this Benefit the Group Plan Deductible or Group Plan Out-Patient Per Visit Excess does not apply. (ii) 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, inlays 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; Dental implant; and prescribed Drugs and Dressings. No other Treatment is covered by this Benefit. Waiting Period: Costs incurred within nine months from the Entry Date are excluded. A Co-Insurance of 20% applies. A 50% Co-Insurance applies in respect of all orthodontic Treatment. For this Benefit the Group Plan Deductible or Group Plan Out-Patient Per Visit Excess does not apply.	(i) Up to USD 1,000 per Period of Cover (ii) Up to USD 2,000 per Period of Cover

Benefit

Excel

31. 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 (AED 100) per night.
- (vi) Essential **Vaccinations** and inoculations for newborns and children as stipulated in the DHA policies and its updates, in assigned facilities covered up to a limit of USD 28 (AED 100).
- (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 gynaecology 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 and checks and tests in accordance with the DHA antenatal Protocols. Initial investigations 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 2,750 for normal Pregnancy and USD 2,750 for C-section per **Insured Person**, per **Period of Cover**.
- 10% **Co-Insurance** payable by the Insured for all **Out-Patient** and **In-Patient** maternity services.
- (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).
- (xi) Psychiatry and Mental Health: Outpatient counselling covered up to USD 218 (AED 800) per year subject to a 30% coinsurance payable by the insured per visit.
- (xii) Influenza Vaccine covered once a year. Unless otherwise indicated these Benefits will not be payable for **Treatment** outside the United Arab Emirates.
- (xiii) Organ transplantation: Coverage up to limit of USD 27,226 (AED 100,000) for recipient only. 20% coinsurance payable by the insured per visit for outpatient visits.
- (xiv) Dialysis: Covered to a limit of USD 16,336 (AED 60,000). 20% coinsurance payable by the insured per visit for outpatient visits.
- (xv) Dental Benefits: Dental consultation, extraction, fillings, root canal treatment, scaling, x-rays, antibiotics and prophylaxis covered up to USD 137 (AED 500). 30% coinsurance payable by the insured per visit for outpatient visits. No coinsurance applicable if a follow-up visit is made within 7 days.
- (xvi) Repatriation costs for the transport of mortal remains to the country of origin: Coverage up to limit of USD 1,362 (AED 5,000)
- (xvii) Hearing and vision aids, and vision correction by surgeries and laser: Excluded healthcare services except in cases of medical emergencies. Subject to 20% coinsurance.

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.

****Note:** Above mentioned benefits are the minimum required DHA benefits however if client has opted for the upgraded plan (enhanced benefits) he/she will avail the benefits under the enhanced coverage.

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.

Benefit

Excel

32. 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 concerning the Regulations of Work Relations, as amended and applicable laws in this respect.

Options to Core Benefits	Excel
33. 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 up to Your Out-Patient Benefit limit. In-Patient and Day-Patient Treatment that is not received in the Now Health International Provider Network will be subject to a 50% Co-Insurance. This option is not available if You have selected an optional Regional Cover.	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
34. 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, 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.	Optional
35. 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, 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.	Optional
36. 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 one of the Out-Patient Per Visit Excess options or one of the Co-insurance Plan options, these will still apply in the Restricted Network.	Optional

Additional Options for Group Plans

Excel

37. Maternity (No Co-Insurance):

Medically Necessary costs incurred during **Pregnancy** and childbirth for pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary or emergency 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 teaching classes as these are a matter of personal choice.

Claims for any caesarean sections are only recoverable from us if you have a maternity **Benefit** as part of your policy. They are not covered by any other **Benefit**.

The **Group Plan Deductible** would apply to the **Benefit**.

The **Group Plan Deductible** option is not available for members with resident visas within the Emirates of Dubai and Abu Dhabi.

Optional

For Compulsory
Group Plans
10+ employees

Up to
USD 12,500 limit
per **Period of Cover**

38. Maternity (10% Co-Insurance):

Medically Necessary costs incurred during **Pregnancy** and childbirth for pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary or emergency 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.

A **Co-Insurance** of 10% applies.

Please note, **We** do not pay for parenting or other teaching classes as these are a matter of personal choice.

Claims for any caesarean sections are only recoverable from us if you have a maternity **Benefit** as part of your policy. They are not covered by any other **Benefit**.

The **Group Plan Deductible** applies to this **Benefit**.

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

Optional

For Compulsory
Group Plans
10+ employees

Up to
USD 12,500 limit
per **Period of Cover**

39. Wellness, Optical and Vaccinations:

(i) **Wellness:** This **Benefit** is payable as a contribution towards the cost of routine health checks including **Cancer** screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age). and/or

(ii) **Optical Benefits:** This **Benefit** also provides a contribution towards optician charges including an annual eye test carried out by an Ophthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, and Laser Eye Surgery and any complications, 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

(iii) **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.

Optional

For Compulsory
Group Plans
3+ employees

Combined limit
Up to USD 500
per **Period of Cover**

Additional Options for Group Plans	Excel
40. Wellness, Optical and Vaccinations Option 2: (i) Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age). and/or (ii) Optical Benefits: This Benefit also provides a contribution towards optician charges including an annual eye test carried out by an Ophthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, and Laser Eye Surgery and any complications, within the combined Benefit limits to a maximum USD 600 per Period of Cover for an optical claim. Please note that there is no cover for prescription sunglasses or transition lenses. and/or (iii) 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.	 Optional For Compulsory Group Plans 3+ employees  Combined limit Up to USD 1,000 per Period of Cover
41. Wellness and Vaccinations Option 3: (i) Wellness: This Benefit is payable as a contribution towards the cost of routine health checks including Cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age). and/or (ii) 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.	 Optional  Combined limit Up to USD 250 per Period of Cover
42. Medical History Disregarded: Please note that the Waiting Period does not apply to either the Pregnancy Medical Conditions, Maternity, Dental Care or Hospital Cash (ii) Benefits, if Medical History Disregarded is selected.	 Optional For Compulsory Group Plans 10+ employees
43. Removal of Dental Co-Insurance: No Co-Insurance will be applied to Dental Care.	 Optional For Compulsory Group Plans 10+ employees

Additional Options for Group Plans

Excel

44. 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 (including air ambulance if required) 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

Following an **Evacuation** covered by **Us**, 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.

We do not cover standalone repatriation.

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

Pre-Authorisation

 Optional

- (i)  Full refund
- (ii)  Full refund
- (iii)  Full refund
- (iv)  Up to USD 200 per day
Up to USD 7,500 per person, per **Evacuation**

Pre-Authorisation

 Full refund

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:

If **Your Group Plan** also includes Dental care **Benefit**, as detailed in **Your Benefit Schedule**, no **Out-Patient Per Visit Excess** will be applicable.

Please note that the **Out-Patient Per Visit Excess** will not apply to Consultation relating to Renal dialysis/Renal failure, **Cancer** or Organ Transplants.

 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:

If **Your Group Plan** also includes Dental care **Benefit**, as detailed in **Your Benefit Schedule**, no **Out-Patient Per Visit Excess** will be applicable.

Please note that the **Out-Patient Per Visit Excess** will not apply to Consultation relating to Renal dialysis/Renal failure, **Cancer** or Organ Transplants.

 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.

Deductible Options	Excel
Standard Deductible	<i>Nil</i>
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 44 .	<i>USD 150</i> <i>USD 250</i> <i>USD 500</i> <i>USD 1,000</i> <i>USD 2,500</i> <i>USD 5,000</i> <i>USD 10,000</i> <i>USD 15,000</i>

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

Benefit	Apex
Annual Maximum Group Plan Limit 24/7 helpline and assistance services available on all Group 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 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 during surgery. This includes pre and post-operative consultations while an In-Patient or Day-Patient and includes charges for intensive care. (ii) Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS) when supplied within 6 months of In-Patient or Day-Patient Hospital Treatment for an Eligible Medical Condition , which is prescribed by Your treating Medical Practitioner . We will pay for the following items: i. Purchase or rental of crutches, air boots and initial purchase or rental of a wheelchair (self-propelled) ii. Delivery systems for prescribed drugs and dressings iii. Orthotic supplies such as insoles and orthotic supports iv. External prosthetics required after surgery. These include braces and calipers, initial purchase and fitting of an artificial limb and artificial eyes. Excludes hearing aids.	(i)  Full refund Pre-Authorisation for (i) 📄 (ii)  Up to USD 4,000 per 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, MRI, CT 📄  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) 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 (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
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	Apex
9. Pregnancy Medical Conditions: <i>In-Patient Treatment</i> of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. We would only allow Treatment of the following as an Eligible Medical Condition under this Benefit: • 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 This benefit does not provide any cover for voluntary or Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. Waiting Period: Costs Incurred within 12 months from the Start Date of the mother are excluded.	Full refund
10. New Born Cover: <i>In-Patient Treatment</i> 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 Group 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 150,000 per Period of Cover
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: <i>In-Patient Treatment</i> 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 150,000 per Period of Cover
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

Benefit	Apex
16. In-Patient Psychiatric Treatment: <i>In-Patient Treatment</i> 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 Cover
17. Terminal Illness: <i>Palliative and Hospice Care:</i> 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
18. Emergency Non-Elective Treatment USA Cover: <i>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.</i> <i>Charges relating to routine Pregnancy and Pregnancy Medical Conditions are specifically excluded from this Benefit.</i>	 Accident: Full refund for Accident requiring In-Patient and Day-Patient care  Illness: In-Patient and Day-Patient care up to USD 50,000 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: Evacuation <i>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> <i>Reasonable expenses for:</i> (i) Transportation costs (including air ambulance if required) 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. <i>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.</i> 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 <i>Following an Evacuation covered by Us, 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.</i> We do not cover standalone repatriation. <i>Charges relating to routine Pregnancy and Pregnancy Medical Conditions are specifically excluded from this Benefit.</i>	Pre-Authorisation 📞 (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 📞  Full refund
20. Mortal Remains: <i>In the event of death from an Eligible Medical Condition, Reasonable and Customary Charges for:</i> (i) Costs of transportation of body or ashes of an Insured Person to his/her 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.	Pre-Authorisation 📞 (i)  Full refund (ii)  Up to USD 20,000

Benefit	Apex
21. Hospital Cash Benefit: i) This Benefit is payable when 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. This Benefit is not payable if the Insured Person is Eligible for Hospital Cash Benefit ii) Major Elective Surgery. This Benefit is limited to a minimum of 30 days between Eligible admissions, and up to a maximum of 5 admissions per policy year. ii) This Benefit is payable when an Insured Person undergoes Major Elective Surgery 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. This Benefit is subject to pre-approval and subject to a minimum of 30 days between Eligible admissions, and up to a maximum of 3 admissions per policy year. For this Benefit exclusion 5.10 does not apply. This Benefit is not payable if your admission and this Benefit is not pre-approved. This Benefit is not Eligible if You are admitted for an Accident and Emergency. Waiting Period: Cover only available after nine months of continuous membership.	Pre-Authorisation ☁ ▶ i) Up to USD 200/EUR 160/GBP 125 per admission ii) Up to USD 1,000/EUR 800/GBP 625 per Major Elective Surgery
22. Out-Patient Charges: (i) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. (ii) Teleconsultation (Virtual Doctor appointments via electronic means). Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the Now Health International Provider Network. Treatment that is not received in the Now Health International Provider Network will pay Reasonable and Customary Charges. No Out-Patient Co-Insurance or Out Patient visit Excess is applicable. (iii) Vitamins and Minerals: Vitamins and Minerals as prescribed by a Medical Practitioner. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the Out-Patient Benefit. Any pre-operative and post-hospitalisation consultations are payable under this Benefit.	(i) and (ii) ▶ Full refund (iii) ▶ Up to USD 150 per Period of Cover
23. Menopause Hormone Replacement Therapy: The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and Treatment commence below the age of 40 years.	▶ Up to USD 750 per Period of Cover
24. 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
25. Out Patient Psychiatric Illness: Out-Patient Treatment administered by a Registered Psychologist and/or a Registered Psychiatrist, subject to 20 sessions and the cost limit under this section. For the first 5 sessions You may choose to visit a Registered Psychologist directly without the need for referral. However, any subsequent sessions with a Registered Psychologist will require referral and a Treatment Plan with a Medical Practitioner or Specialist.	▶ Up to USD 7,500 and subject to a maximum of 20 sessions per Period of Cover
26. Out-Patient Physiotherapy and Alternative Therapies: (i) Physiotherapy by a Registered Physiotherapist. (ii) Complementary medicine and Treatment by a therapist. This Benefit extends to osteopaths, chiropodists and podiatrists, chiropractors, homeopaths, dietician and acupuncture Treatment but excludes Physiotherapist covered in (i). You may choose 5 sessions for any combination of Benefits in aggregate in a given Period of Cover for Benefits (i) and (ii) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist. Please note that sessions must be conducted at a recognised medical facility or an approved healthcare center. Home-based sessions are not covered.	(i) ▶ Full refund (ii) ▶ Full refund Pre-Authorisation for (i) and (ii) after every 10 visits ☁

Benefit	Apex
27. Out-Patient Traditional Chinese Medicine and Ayurvedic Medicine: Out-Patient Treatment for therapies administered by a recognised Traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. All claims to include diagnosis, consultation fee, Treatment type, Treatment fee, prescription including detailed medication and number of doses. Exclusion 5.35 applies.	▶ Up to USD 3,000 per Period of Cover
28. 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 120 days per Medical Condition Pre-Authorisation for (i) ☎ (ii) ▶ Up to five visits per Period of Cover
29. 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; and a positive HIV test occurred within 12 months of the reported occupational Accident. ** 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-Authorisation ☎ ▶ Up to USD 50,000 per Period of Cover
30. Maternity (No Co-Insurance): Medically Necessary costs incurred during Pregnancy and childbirth for pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary or emergency 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. Claims for any caesarean sections are only recoverable from us if you have a maternity Benefit as part of your policy. They are not covered by any other Benefit. The Group Plan Deductible would apply to this Benefit. Please note Group Plan Deductibles are not available to Insured Persons with residence visas in the Emirates of Dubai or Abu Dhabi.	▶ Up to USD 17,500 per Period of Cover

Benefit

Apex

31. 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 (twice 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**).
 - Prescribed **Drugs and Dressings**.

No other **Treatment** is covered under the routine dental **Treatment Benefit**.

Waiting Period: Costs incurred within nine months from the **Entry Date** are excluded.

A **Co-Insurance** of 20% applies.

For this **Benefit** the **Group Plan Deductible** or **Group Plan Out-Patient Per Visit Excess** does not apply.

- (ii) 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, inlays 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; Dental implant; and prescribed **Drugs and Dressings**.

No other **Treatment** is covered by this **Benefit**.

Waiting Period: Costs incurred within nine months from the **Entry Date** are excluded.

A **Co-Insurance** of 20% applies.

A 50% **Co-Insurance** applies in respect of all orthodontic **Treatment**.

For this **Benefit** the **Group Plan Deductible** or **Group Plan Out-Patient Per Visit Excess** does not apply.

- (i) 
Up to USD 1,500
per **Period of Cover**

- (ii) 
Up to USD 3,000
per **Period of Cover**

Benefit

Apex

32. 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 (AED 100) per night.
- (vi) Essential **Vaccinations** and inoculations for newborns and children as stipulated in the DHA policies and its updates, in assigned facilities covered up to a limit of USD 28 (AED 100).
- (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 gynaecology 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 and checks and tests in accordance with the DHA antenatal Protocols. Initial investigations 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 2,750 for normal Pregnancy and USD 2,750 for C-section per **Insured Person**, per **Period of Cover**.
- 10% **Co-Insurance** payable by the Insured for all **Out-Patient** and **In-Patient** maternity services.
- (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).
- (xi) Psychiatry and Mental Health: Outpatient counselling covered up to USD 218 (AED 800) per year subject to a 30% coinsurance payable by the insured per visit.
- (xii) Influenza Vaccine covered once a year. Unless otherwise indicated these Benefits will not be payable for **Treatment** outside the United Arab Emirates.
- (xiii) Organ transplantation: Coverage up to limit of USD 27,226 (AED 100,000) for recipient only. 20% coinsurance payable by the insured per visit for outpatient visits.
- (xiv) Dialysis: Covered to a limit of USD 16,336 (AED 60,000). 20% coinsurance payable by the insured per visit for outpatient visits.
- (xv) Dental Benefits: Dental consultation, extraction, fillings, root canal treatment, scaling, x-rays, antibiotics and prophylaxis covered up to USD 137 (AED 500). 30% coinsurance payable by the insured per visit for outpatient visits. No coinsurance applicable if a follow-up visit is made within 7 days.
- (xvi) Repatriation costs for the transport of mortal remains to the country of origin: Coverage up to limit of USD 1,362 (AED 5,000)
- (xvii) Hearing and vision aids, and vision correction by surgeries and laser: Excluded healthcare services except in cases of medical emergencies. Subject to 20% coinsurance.

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.

****Note:** Above mentioned benefits are the minimum required DHA benefits however if client has opted for the upgraded plan (enhanced benefits) he/she will avail the benefits under the enhanced coverage.

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.

Options to Core Benefits

Apex

33. 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 concerning the Regulations of Work Relations, as amended and applicable laws in this respect.

34. 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 up to **Your Out-Patient Benefit** limit.

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

This option is not available if **You** have selected an optional **Regional Cover**.

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**

35. 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, 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.

Optional

36. 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, 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.

Optional

37. 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 one of the **Out-Patient Per Visit Excess** options or one of the **Co-Insurance Plan** options, these will still apply in the **Restricted Network**.

Optional

Additional Options for Group Plans

Apex

38. Maternity (10% Co-Insurance):

Medically Necessary costs incurred during **Pregnancy** and childbirth for pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary or emergency 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.

A **Co-Insurance** of 10% applies.

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.

Claims for any caesarean sections are only recoverable from us if you have a maternity **Benefit** as part of your policy. They are not covered by any other **Benefit**.

The **Group Plan Deductible** would apply to this **Benefit**.

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

Up to USD 17,500
per **Period of Cover**

39. Wellness, Optical and Vaccinations:

(i) **Wellness:** This **Benefit** is payable as a contribution towards the cost of routine health checks including **Cancer** screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age).
and/or

(ii) **Optical Benefits:** This **Benefit** also provides a contribution towards optician charges including an annual eye test carried out by an Ophthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, and Laser Eye Surgery and any complications, 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

(iii) **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.

Optional
For Compulsory
Group Plans
3+ employees

Combined limit
Up to USD 500
per **Period of Cover**

40. Wellness, Optical and Vaccinations Option 2:

(i) **Wellness:** This **Benefit** is payable as a contribution towards the cost of routine health checks including **Cancer** screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age).
and/or

(ii) **Optical Benefits:** This **Benefit** also provides a contribution towards optician charges including an annual eye test carried out by an Ophthalmic Optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, and Laser Eye Surgery and any complications, within the combined **Benefit** limits to a maximum USD 600 per **Period of Cover** for an optical claim.

Please note that there is no cover for prescription sunglasses or transition lenses.
and/or

(iii) **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.

Optional
For Compulsory **Group Plans**
3+ employees

Combined limit
Up to USD 1,000
per **Period of Cover**

41. Wellness and Vaccinations Option 3:

(i) **Wellness:** This **Benefit** is payable as a contribution towards the cost of routine health checks including **Cancer** screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol). Well Child Tests (Up to 5 Years of age).
and/or

(ii) **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.

Optional

Combined limit
Up to USD 250
per **Period of Cover**

Additional Options for Group Plans	Apex
42. Medical History Disregarded: Please note that the Waiting Period does not apply to either the Pregnancy Medical Conditions, Maternity, Dental Care or Hospital Cash (ii) Benefits, if Medical History Disregarded is selected.	 Optional For Compulsory Group Plans 10+ employees
43. Removal of Dental Co-Insurance: No Co-Insurance will be applied to Dental Care.	 Optional For Compulsory Group Plans 10+ employees
44. 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 (including air ambulance if required) 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 Following an Evacuation covered by Us, 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. We do not cover standalone repatriation. Charges relating to routine Pregnancy and Pregnancy Medical Conditions are specifically excluded from this Benefit.	Pre-Authorisation 📞  Optional (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 📞  Full refund
45. Removal of Maternity: If You select this Benefit, no Benefit is payable under Benefit 30 - Maternity Benefit. You will still be eligible for the DHA mandatory maternity Benefit as shown in Benefit 32.	 Optional

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: If Your Group Plan also includes Dental care Benefit, as detailed in Your Benefit Schedule, no Out-Patient Per Visit Excess will be applicable. Please note that the Out-Patient Per Visit Excess will not apply to Consultation relating to Renal dialysis/Renal failure, Cancer or Organ Transplants.	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: If Your Group Plan also includes Dental care Benefit, as detailed in Your Benefit Schedule, no Out-Patient Per Visit Excess will be applicable. Please note that the Out-Patient Per Visit Excess will not apply to Consultation relating to Renal dialysis/Renal failure, Cancer or Organ Transplants.	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.	

Deductible Options	Apex
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 under Benefit 19 and Benefit 44.	USD 150 USD 250 USD 500 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

5. Exclusions: What is not covered?

These are the **Group 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 **Group 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 and Cosmetic Products

We do not pay for 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 hearing aids or cochlear implants. **You** are not covered for routine hearing tests unless a Wellness **Benefit** is shown on **Your Certificate of Insurance**. **You** are not covered for routine eyesight tests or the cost of eyeglasses, contact lenses or laser eye surgery to correct vision unless an Optical **Benefit** is shown on **Your Certificate of Insurance**. **We** do pay for eye surgery to correct an **Eligible Medical Condition**.

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, motor sports, 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 and for Menopause Hormone Replacement Therapy where onset and **Treatment** commence below the age of 40 years.

5.24 Obesity and Weight Loss

You are not covered for costs of **Treatment** for, or related to Bariatric surgery and any complications arising from it. **You are not covered for costs** of **Treatment** for, or related to removing fat or surplus healthy tissue from any part of the body and any complications arising from it. **You are not covered for the costs** of **Treatment** for, or related to weight loss including weight loss medications and any complications arising from them.

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

You are not covered for **Treatment** received in nursing homes, convalescence homes, health hydros, health resorts, health spas, 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 **Pregnancy** or childbirth, voluntary or **Emergency** caesarean section, unless the Maternity **Benefit** is shown on **Your Certificate of Insurance**.

These costs are only covered under the Maternity **Benefit** and are not covered or recoverable under any other **Benefits** (unless specifically covered by **Benefit 9: Pregnancy Medical Conditions**).

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:

1. **You** have received **Treatment**, tests or investigations for, been diagnosed with or been hospitalised for; or
2. **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:

- (i) investigations into or **Treatment** of infertility and fertility, or assisted conception
- (ii) Sterilisation (or its reversal)
- (iii) 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 Traditional Chinese Medicine

You are not covered for the following, Pre-paid treatment **Plan** or pre-paid package prior to **Treatment** being received, Over-the-counter traditional Chinese Medicines, **Treatments** for tonic or cosmetic purposes or weight management. **You** are not covered for the following Traditional Chinese Medicines (whether prescribed or not) including cordyceps; ganoderma; antler; cubilose; donkey-hide gelatin; hippocampus; ginseng; red ginseng; American Ginseng; Radix Ginseng Silvestris; antelope horn powder; placenta hominis; Agaricus blazei murill; musk; pearl powder; rhinoceros horn and substances from Asian Elephant, Sun Bear, Tiger or other endangered species. **You** are not covered for more than one **Treatment** per day.

5.36 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.

5.37 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**.

5.38 Treatment by a family member

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

5.39 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. Group Plan administration

6.1 The contract

The group agreement between **Us** and **Your** company/employer, the group application form, the group employee application form (if applicable) and any supporting documents, the **Certificate of Insurance**, **Benefit Schedule** and this handbook incorporating the **Group Plan** terms and conditions make up the contract between the **Planholder** and **Us**.

Your Plan is underwritten by Arabia Insurance Company S.A.L. and governed by the laws of UAE. As a consequence **Your Plan** may not meet the requirements of the relevant regulations in **Your** territory. Please ensure that **Your Plan** is suitable where **You** reside and that **You** comply with any necessary taxation or other obligations

6.2 Premium payment

In most cases **Your** company/employer is responsible for payment of premiums. At the start of each **Group Plan** year, **We** will calculate **Your** new premium and let the **Plan Administrator** know how much it is.

The **Plan Administrator** must pay **Your** premium when it is due. **We** must receive premiums 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 the **Plan Administrator** does not, **We** will cancel **Your Benefits** and will not pay for any **Treatment** or **Benefit** entitlement arising after the date that the premium became due.

You are not allowed to change the currency of **Your Plan** at renewal of **Your Plan** unless **You** change the **Country of Residence**, and the currency change (if any) is subject to underwriting.

6.3 Eligibility

6.3.1 Entry 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.

6.3.2 Actively at Work

Actively at Work shall mean **You** are employed by the **Planholder** on a full time permanent basis and **You** are performing all **Your** regular duties according to **Your** employment terms on a customary manner and on a full time basis.

If **You** are an employee, **You** need to be Actively at Work on the day **You** become **Eligible** to join the **Group Plan**. If **You** are not Actively at Work on the day **You** become **Eligible**, **Your** cover will only begin on the day **You** return to work on an Actively at Work basis. **You** can only add **Your Dependants** when **You** return to work.

You are considered NOT being Actively at Work if:

- **You** are working less than 80% of the required work hours or being paid less than 80% of the usual pay as stipulated in **Your** employment terms
- **You** have a **Medical Condition** that necessitates absence from **Your** usual work place for more than 60 days, with the exception of maternity/paternity leave as allowed by the local regulations.

6.3.3 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 **Group Plan**.

6.3.4 Non-Eligible Residency

If **You** permanently reside in a country that is not covered by this **Group Plan** and which **We** have advised at **Renewal Date**, **You** are not **Eligible** for this **Group Plan**. For details of the excluded countries please contact **Our** customer service team on + 971 (0) 4450 1410.

6.4 Adding a new Dependant

Subject to the terms and conditions of **Your Group Plan**, if subsequently **You** wish to add **Your** spouse, partner or child to **Your Group Plan**, the **Plan Administrator** must either use their online secure portfolio area at www.now-health.com or arrange for **You** to complete a new application form, if applicable. 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 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 Group Plan** with **Us** will be governed by the terms and conditions of this **Group Plan**. The acceptance by **Us** of **Your** original **Entry Date** will be applied to **Your Group Plan** with **Us** and any transfer will be subject to no enhanced **Benefits** being provided.

Should **Your Group Plan** come to an end **You** can apply to transfer to one of **Our** Individual WorldCare **Plans**. **Your** application must be submitted to **Us** before **You** leave the **Group Plan** and acceptance 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.

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 service 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 service team on T +971 (0) 4450 1410 or CustomerService@now-health.com in the first instance.

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 and investigate.

After investigating, We will provide to You a response. If there is an unavoidable delay, **We** will inform **You** of this.

Our aim is to resolve **Your** complaint satisfactorily and **We** will inform **You** of the outcome.



Step 2

We hope to resolve **Your** complaint satisfactorily. However, if **You** are unhappy with the outcome **You** have received from **Us** and remain dissatisfied, **You** may refer **Your** complaint to the relevant Authorities below.

For Dubai Health Insurance complaints, **You** can contact the Dubai Health Authority (DHA) using the details below:

Website: <https://www.isahd.ae/Home/Ipromes>

Email: info@dha.gov.ae

Telephone: 800342 (800 DHA) [Toll Free (24/7)]

For Abu Dhabi Health Insurance complaints, **You** can contact the Health Authority of Abu Dhabi (HAAD) using the details below:

Website: <https://www.doh.gov.ae/en/Request-For-Submitting-Health-Insurance-Complaint>

Email: contact@abudhabi.ae

Telephone: +971 2449 3333 or Local Toll-Free Number: 800 555

For any Regulatory Health Insurance Complaints, **You** can contact SANADAK "Ombudsman Unit For The UAE" using the details below:

Website : Homepage - Sanadak

Email: help@sanadak.ae

Telephone: 800SANADAK (800 72 623 25)

Address: SANADAK Unit – Emirates Institute of Finance Building – Ground Floor – Sultan Bin Zayed The First Street – Abu Dhabi.

8. Rights and responsibilities

The group agreement between **Us** and **Your** company/employer, the group application form, the group employee application form (if applicable) and any supporting documents, the **Certificate of Insurance**, **Benefit Schedule** and this handbook incorporating the **Group Plan** terms and conditions make up the contract between the **Planholder** 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 **Your** cover under the **Group Plan** (including not returning the **Group 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 **Group Plan** premium and reduce **Your** claim(s).
- 8.1.2** Apart from certain countries where **We** have explicitly agreed to cover local nationals, this **Group Plan** is available only to people living outside their **Country of Nationality** so **You** must tell **Us** immediately via the **Plan Administrator** 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.
- 8.1.3** Only **We** and the **Planholder** have legal rights under this **Group Plan** and it is not intended that any clause or term of this **Group Plan** should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any family member.
- 8.1.4** **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**.
- 8.1.5** This **Group 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.
- 8.1.6** 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 administering **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 service 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 **Group Plan** starts and any special terms which apply to it.

We can refuse to give cover and will tell the **Planholder** 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 the **Planholder's** acceptance.

8.2.3 **We** can refuse to add a family member to the **Group 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 **Group 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** or the **Planholder** any loss to **Us** caused by the break
- Refuse to renew **Your Benefits** under the **Group Plan**
- Impose different terms to any cover **We** are prepared to provide
- End **Your Group 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 **Group 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 Group 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 **Your Benefits** void, as if it never existed. If **We** have already paid the **Benefit** **We** can recover those sums from **You** or the **Planholder**. 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 the **Plan Administrator**. **We** reserve the right to revise or discontinue the **Group 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 Malta, 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 **Group Plan** is written in English and all other information and communications to **You** relating to this **Group Plan** will also be in English unless **We** have agreed otherwise in writing.



Plans issued in the United Arab Emirates (UAE) are insured by Arabia Insurance Company S.A.L. (registered under UAE Federal Law No (6) of 2007 and regulated by CBUAE) with the Registration No: 20)

Registered address: Arabia Insurance, Green Tower, Floor No 8, 9 and 10. P.O. Box 1050 Dubai United Arab Emirates.

Plans are administered by Now Health International Gulf Third Party Administrators LLC (regulated by CBUAE with the Registration No: 26).

Registered address: Office No: 1741, Al Ghaith Tower, Aya Business Centers – Branch 1, Hamdan Street, Al Dannah, Abu Dhabi, United Arab Emirates

Now Health International

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