

Elite Health Plan Agreement for Employees

For employees with an Elite Health plan
whose period of cover starts on or after
01 January 2018



دبي للتأمين
DUBAI INSURANCE

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Introducing your health plan

Welcome

We want to provide **you** with an insurance policy **you** can rely on, so it is important that **you** fully understand the scope of the cover **we** provide. This **agreement** explains what is and what is not covered by **your plan**, and how **your claims** will be administered.

Please take time to read this **agreement** along with **your employer's master certificate of insurance**, **your own certificate of insurance**, and **your application form**. Together, these documents form the contract between **your employee**, **you** and **us**.

Certain words **we** use within this **agreement** have a special meaning to which **we** would like to draw **your** attention. For example:

- **'We, us, our'** – means Dubai Insurance Company psc.
- **'You, your'** – means **you** and all **insured persons** on this **plan**, as shown on **your certificate of insurance**
- **'Policyholder'** – means **your** company or **employer** who has the insurance contract with **us**
- **'Assistance Service'** – means the company **we** have appointed to provide **you** with 24-hour medical assistance while **you** are travelling outside of Dubai

These words appear in **bold** type, and we provide their precise meanings in the 'Definitions' section of this **agreement**.

All web addresses in this **agreement** are live. Simply click on a link and **you** will be taken directly to **our** website. **We** are, of course, always at the end of a telephone to answer queries or deal with **your claim**. **You** can find **our** contact details below.

Dubai Insurance Company psc.

Dubai Insurance Company psc. is the administrator and the **insurer** of **your plan**. Dubai Insurance Company psc. is licensed by the UAE Insurance Authority under registration number 4.

Neuron LLC

Neuron LLC is the company we have appointed to administer and settle **your** network and reimbursement claims.

William Russell Ltd.

William Russell Ltd. is the designer of the Elite Health plans and the inspiration behind the benefits **we** offer **you** and the customer experience **we** provide to **you**.

Contact details

If you have an enquiry about your plan or insurance	Tel +971 4 269 7708 Fax +971 4 269 1304 Email enquiries@globalplans.ae
If you need to make a claim	Helpline (toll free) 800 4408 Helpline (not toll free) +971 4 341 4770 General fax +971 4 385 3699 In-patient fax +971 4 382 3610 Out-patient fax +971 4 382 3620 Web neuron.ae
If you need to contact our 24-hour emergency medical Assistance Service	Tel +44 1232 621 155
If you'd like to write to us	Global Plans Team Dubai Insurance Company PO Box 3027 Dubai, UAE
If you'd like to write to Neuron	Neuron LLC PO Box 72071 Dubai, UAE

Your plan agreement

This **agreement** is subject to the terms, conditions and exclusions of the **master certificate of insurance** we issue to **your employer**. A copy of this is available from **your employer**.

The terms of this **agreement** apply to **you** and to all of **your eligible dependants**, as stated in the schedule of **insured persons** on **your certificate of insurance**.

Eligibility to join your employer's plan

Eligibility to join the **plan** is as agreed between **us** and **your employer** and is shown on **your employer's master certificate of insurance**.

If **you** are eligible to join, **you** must join within 30 days of becoming eligible to do so.

Your eligible dependants must also join the **plan** at the same time as **you** join, or, within 30 days of becoming eligible to do so if they only become eligible to join at a later date.

If **you** or **your** dependants do not join within 30 days of becoming eligible to do so **we** may only offer cover subject to **special terms**.

The purpose of your plan

Your plan provides **you** with cover for treating eligible medical conditions during **your period of cover**.

We will pay for the **reasonable and customary** cost of **medically necessary treatment** for medical conditions covered by **your plan**. **We** will only pay for such **treatment** if it is received during **your period of cover**, and provided **your premium** payments have been kept up to date by **your employer**.

Any reimbursement **we** make may be subject to an **excess** and/ or **co-insurance**, and certain benefits are subject to a benefit limit. **Your excess** amount will be stated on **your certificate of insurance**. Any **co-insurance** and benefit limits will be as stated in the **table of benefits** for **your plan type**.

Your obligation to provide information relating to your own, and to your eligible dependants' medical history

We rely on the information **you** supply to **us** in **your application form** when **we** decide whether or not **we** need to apply **special terms**.

If **your application form** omits facts or contains materially incorrect or incomplete facts, **we** have the right to declare **your plan** void. Alternatively **we** may impose **special terms** on **your particular plan** which will apply from **your date of entry**.

If **your** state of health, or the state of health of any of **your eligible dependants** changes between the time **you** complete **your application form** and **your date of entry**, **you** must tell **us** in writing about the change, and **we** may only be able to accept **your application** with **special terms**.

Pre-existing medical conditions and related conditions

Provided **you** have given **us** full and complete answers to the health questions in **your application form** in respect of all **insured persons**, and **your employer** has paid any additional **premium** that may have been charged, **your plan** covers **you** for **treatment** of **pre-existing medical conditions and related conditions**.

Commencement of your cover

Your cover will commence from the **date of entry** stated on **your certificate of insurance**. **We** will not commence **your** cover until **we** have accepted **your application** and **your employer** has paid the **premium**.

If the USA is or becomes your country of residence

Under the terms of this **agreement** cover is not available to **you** if the USA is or becomes **your country of residence**, irrespective of **your** nationality. If the USA becomes **your country of residence** **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the USA.

Eligible medical services providers

The Neuron network of **medical services providers** **you** are entitled to use is as stated on **your certificate of insurance** and on **your Neuron network card**.

If **your** cover is restricted to the benefits of the Dubai Primary Benefits plan **you** will only be entitled to use a **medical services provider** within **Ultra-Restricted network**. If **you** use a **medical services provider** that is not in **Ultra-Restricted network** **we** will not reimburse **your claim**.

Your area of cover

The cover provided by **your plan** is restricted to the **area of cover** stated on **your certificate of insurance**. The available areas of cover and their corresponding territorial limits are stated below.

Standard area of cover

The standard **area of cover** is worldwide, excluding the United States of America. No cover is provided for any medical **treatment** in, or emergency medical evacuations to, within or from, the United States of America.

Enhanced areas of cover

There are two **areas of cover** that provide worldwide cover, with limited cover in the United States of America. If **you** have one of these **areas of cover**, it will be stated on **your certificate of insurance**.

Worldwide with 45 days of USA cover

We will cover **you** in the USA for temporary trips of up to 45 days' duration from the date on which **you** enter the United States of America. Any trip of longer than 45 days will not be covered. There is no limit to the number of temporary trips **you** can make to the United States of America during any **period of cover**. The maximum amount **we** will pay in respect of **treatment you** receive in the United States of America is US\$100,000 per **period of cover**, unless the payment is in respect of **emergency treatment** for a condition covered by **your plan** following an **accident** or a sudden and unforeseen illness **you** have never suffered from before, in which case the maximum **we** will pay is US\$250,000 per **period of cover**.

Worldwide with 90 days of USA cover

We will cover **you** in the United States of America for temporary trips of up to 90 days' duration from the date on which **you** enter the United States of America. Any trip of longer than 90 days will not be covered. There is no limit to the number of temporary trips **you** can make to the United States of America during any **period of cover**. The maximum amount **we** will pay in respect of **treatment you** receive in the United States of America is US\$250,000 per **period of cover**.

Restricted areas of cover

One **area of cover** provides regional cover only. If **you** have this **area of cover**, it will be stated on **your certificate of insurance**.

Ultra-Restricted network

Cover is restricted to the **medical network providers** within **Ultra-Restricted network**, all of which are located within the United Arab Emirates.

What you are covered for

The following **table of benefits** sets out the cover provided by each **plan type**. The **plan type** you have is as shown on **your certificate of insurance**. We will pay only for the **treatment** or services stated in the **table of benefits** relating to **your plan**.

Each benefit limit in the **table of benefits** is expressed in US Dollars and United Arab Emirates Dirhams. The currency of the benefit limits that we will apply to **your plan** is shown on **your certificate of insurance**.

The limits shown in the **table of benefits** are the maximum amounts we will pay after the application of any **excess** and **co-insurance**, and will be subject to the annual benefit limit and any other specified applicable benefit limits.

Certain benefits in the **table of benefits** specify a **waiting period**. You must be covered by the same **plan** for the full duration of the specified **waiting period** before you can claim for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**.

Wherever the term 'Full cover' appears in the **table of benefits**, this means full refund of **reasonable and customary** charges, less any **excess** or **co-insurance** applicable to **your plan**, and subject to any limits that are specified anywhere else in the **table of benefits** for the type of **treatment** or care you receive.

Where there is a lifetime benefit limit, this is the maximum amount

we will pay in respect of that particular benefit during **your** lifetime.

Certain benefits in the **table of benefits** are optional. You are only eligible for these benefits if **your employer** has selected them and they are stated on **your certificate of insurance**.

There are certain benefits in the **table of benefits** for which you must obtain pre-authorization.

The **table of benefits** should be read in conjunction with the 'What you are not covered for' section of this **agreement**.

In the event that cover in respect of any benefit set out in the Silver or Gold **plan** is lower than the benefit provided under the **Dubai Health Authority Essential Benefits plan**, the cover provided under the **Dubai Health Authority Essential Benefits plan** shall apply.

If you have **your treatment** at a **medical services provider** which is not within the Neuron network stated on **your Neuron network card**, penalties will apply. Please refer to the 'If you need to make a **claim**' section of this **agreement** for further information.

If **your plan type** is the Dubai Primary Benefits **plan**, which provides cover for **medically necessary treatment** at a **medical services provider** within **Ultra-Restricted network**, please refer to the **table of benefits** on pages 28-30 of this **agreement**.













Key ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Silver	Gold
<p>Annual benefit limit</p> <p>The overall maximum limit that each insured person can claim during any one period of cover.</p>	US\$2,500,000 or AED9,175,000	US\$5,000,000 or AED18,350,000
<p>Hospital costs</p> <p>Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorization for all benefits included in this section. 		
<p>Hospital accommodation</p> <p>The cost of a standard single room with an en-suite bath or shower room, when you are an in-patient or day-patient.</p>	○ Full cover	○ Full cover
<p>Hospital treatment</p> <p>Treatment you receive while you are an in-patient or day-patient, including surgeons' and anaesthetists' and doctors' fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, diagnostic tests and physiotherapy.</p> <p>We will also pay for pre-admission tests that you undergo on an out-patient basis for hospital treatment you are scheduled to receive that is covered by your plan.</p> <p>We will also pay for in-patient surgical removal of impacted, buried or unerupted wisdom teeth. This is subject to a 12-month waiting period and covered only when the surgery is performed by a medical doctor (not a dentist) in a hospital (not a dental surgery) and under general anaesthetic.</p>	○ Full cover	○ Full cover

Key ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Silver	Gold
<p>Hospital costs (continued) Important notes: • You must obtain pre-authorisation for all benefits included in this section.</p>		
<p>Parent accommodation The cost of one parent staying in hospital with a child under 18 years of age while the child is receiving eligible treatment covered by their plan.</p>	○ Full cover	○ Full cover
<p>Accommodation of an accompanying person Accommodation for an accompanying person in the same room in cases of critical conditions as recommended by the attending medical doctor/specialist.</p>	○ Full cover	○ Full cover
<p>Road ambulance The cost of a private road ambulance if you need hospital treatment covered by your plan and if it is medically necessary for you to travel to hospital by ambulance.</p>	○ Full cover	○ Full cover
<p>Hospital cash benefit Payable for each night spent in a hospital when you receive treatment eligible for cover by your plan for which no charge is made by the hospital. Benefit is paid for up to a maximum of 60 nights per period of cover.</p>	US\$80 or AED294 per night	US\$250 or AED918 per night
<p>Cancer treatment Important notes: • You must obtain pre-authorisation for all benefits included in this section.</p>		
<p>Cancer treatment Cancer treatment, including chemotherapy, radiotherapy, immunotherapy, consultations, tests, scans, and drugs. We will also pay for restorative dental treatment following chemotherapy or radiotherapy.</p>	○ Full cover	○ Full cover
<p>Cancer genome tests The cost of tests to sequence the genes of cancer cells.</p>	○ Cover up to US\$6,000 or AED22,020 per period of cover	○ Cover up to US\$6,000 or AED22,020 per period of cover
<p>Cash benefit upon diagnosis of cancer (6-month waiting period) Payable if you are diagnosed with cancer. By ‘cancer’ we mean the presence of tumours that consist of cells that are malignant, due to characteristics which can be shown microscopically. These cells can multiply and spread to other parts of the body uncontrollably – cancers such as breast cancer, lung cancer, bowel cancer and cancers of the blood (also known as leukaemia). The following are not covered: • non-melanoma skin cancer unless it has spread to lymph nodes or organs • prostate cancer unless it has spread to other glands or organs This benefit will not be paid if you were first diagnosed with any cancer before you were covered under the Gold plan for a period of six consecutive months.</p>	○ No cover	US\$5,000 or AED18,350 with a lifetime limit of one claim per insured person
<p>Wigs Help towards the cost of a wig following chemotherapy, covered by your plan.</p>	○ Lifetime limit of US\$150 or AED551	○ Lifetime limit of US\$150 or AED551
<p>Counselling Consultations with a registered psychologist/counsellor when you have received cancer treatment covered by your plan, up to a lifetime limit of 10 consultations. We do not cover any drugs prescribed under this benefit.</p>	○ Lifetime limit of US\$500 or AED1,835	○ Lifetime limit of US\$500 or AED1,835

















Key  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Silver	Gold
<p>Cancer treatment (continued) Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorization for all benefits included in this section. 		
<p>Dietitian Consultation with a registered dietitian when you have received cancer treatment covered by your plan, up to a lifetime limit of 2 consultations.</p>	 Lifetime limit of US\$100 or AED367	 Lifetime limit of US\$100 or AED367
<p>Organ, bone marrow or tissue transplants Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorization for all benefits included in this section. We only cover transplants carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO (World Health Organisation) guidelines. We do not cover any costs associated with the acquisition of the organ. 		
<p>Transplant and related treatment Costs incurred while hospitalised, including anti-rejection drugs, and all related out-patient treatment required prior to and after the transplant.</p>	 Full cover	 Full cover
<p>Donor costs Medical costs associated with the donor as an in-patient or day-patient.</p>	 Cover up to US\$25,000 or AED91,750 per transplant	 Cover up to US\$25,000 or AED91,750 per transplant
<p>Kidney dialysis Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorization for this benefit. 		
<p>Treatment for kidney dialysis while you are an in-patient, day-patient or out-patient.</p>	 Full cover	 Full cover
<p>Reconstructive surgery Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorization for this benefit. 		
<p>A maximum of two surgeries to restore your appearance after an accident or after surgery for cancer, provided the original treatment for the accident or cancer was paid for by us, and provided the reconstructive surgery takes place within two years of the accident or the original cancer surgery.</p>	 Full cover	 Full cover
<p>Congenital conditions or hereditary conditions Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorization for this benefit. 		
<p>Treatment for a congenital condition or hereditary condition (whether diagnosed as a chronic condition or not) and treatment for any related condition. This benefit does not extend to psychiatric treatment or psychotherapy, complimentary medicine, traditional Chinese medicine, acupuncture or homeopathic treatment. There is no cover for congenital conditions or hereditary conditions if, prior to commencement of your cover, you have had any abnormal signs, symptoms or test results related to the congenital condition or hereditary condition (whether or not a specific diagnosis has been made). However, there may be some cover for newborn babies under the newborn babies benefit. Your lifetime limit for this benefit will be reduced by any payments we have made under the newborn babies benefit with respect to birth defects, congenital conditions or hereditary conditions. The lifetime limit shown applies irrespective of the number of congenital conditions and hereditary conditions.</p>	 Lifetime limit of US\$40,000 or AED146,800	 Lifetime limit of US\$80,000 or AED293,600











Key ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Silver	Gold
<p>Psychiatric & psychotherapy treatment Important notes:</p> <ul style="list-style-type: none"> • You must obtain pre-authorisation for all benefits included in this section. • All treatment must be administered under the direct control of a registered psychiatrist or psychologist. • We do not cover investigations or treatment related to psycho-geriatric conditions including Alzheimer's disease or dementia, phobias, hypnotherapy, postnatal depression or marriage counselling. 		
<p>Lifetime psychiatric and psychotherapy treatment limit The overall maximum limit to the amount that you can claim for all psychiatric and psychotherapy treatment covered by your plan during your lifetime.</p>	Lifetime limit of US\$75,000 or AED275,250	Lifetime limit of US\$100,000 or AED367,000
<p>In-patient and day-patient psychiatric and psychotherapy treatment In-patient and day-patient treatment received in a recognised psychiatric or psychotherapy unit of a hospital.</p>	○ Cover for up to 30 days per period of cover	○ Cover for up to 30 days per period of cover
<p>Out-patient psychiatric and psychotherapy treatment Specialist psychiatric consultations with a registered psychiatrist or psychologist when you have been referred by a medical doctor.</p>	○ Cover for up to 10 consultations per period of cover	○ Cover for up to 10 consultations per period of cover
<p>HIV/AIDS treatment Important notes:</p> <ul style="list-style-type: none"> • You must obtain pre-authorisation for this benefit. 		
<p>Treatment arising from or related to Human Immunodeficiency Virus (HIV) and/or HIV-related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) for a maximum period of 5 years. We do not provide cover if the virus was contracted before your date of entry.</p>	○ Cover up to US\$75,000 or AED275,250 per period of cover	○ Cover up to US\$100,000 or AED367,000 per period of cover
<p>Medical appliances Important notes:</p> <ul style="list-style-type: none"> • Any eligible medical aids, prosthetic implants or prosthetic devices will be covered up to the amount of a standard supply used in government/public hospitals. 		
<p>Medical aids Supplying, fitting or hiring instruments, apparatuses or devices which are medically prescribed as a medical aid to you (for example crutches, wheelchairs, orthopaedic supports/braces, orthotics, stoma supplies, compression stockings) when it immediately follows in-patient, day-patient or or emergency ward treatment covered by your plan. We do not cover medical aids that form part of the care of a chronic condition, including, but not limited to, insulin pumps, reservoirs, glucose sensors, lancets, and quickset infusions. We do not cover unprescribed medical aids such as gym equipment, even if you have been advised to use such an aid.</p>	○ Cover up to US\$500 or AED1,835 per medical condition per period of cover	○ Cover up to US\$1,000 or AED3,670 per medical condition per period of cover
<p>Prosthetic implants Surgically-implanted, artificial body parts necessary to replace a joint or ligament, a heart valve, the aorta or an arterial blood vessel, a sphincter muscle, the lens or cornea of the eye, or to control urinary incontinence, or to act as a heart pacemaker, or to remove excess fluid from the brain. As part of this benefit, we will also pay for a knee brace if it is an essential part of a surgical operation for the repair to a knee ligament, and for a spinal support if it is an essential part of a surgical operation to the spine.</p>	○ Full cover	○ Full cover
<p>Prosthetic devices External prosthetic body parts, such as prosthetic limbs, fitted at the time of a surgical operation covered by your plan.</p>	○ Cover up to US\$1,000 or AED3,670 per device	○ Cover up to US\$1,500 or AED5,505 per device

Key  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Silver	Gold
Everyday medical costs		
Primary medical care Visits to a GP or doctor, specialist consultations, prescribed drugs and dressings, pathology, scans, radiology and diagnostic tests received as an out-patient .	 Full cover	 Full cover
Emergency ward treatment Emergency treatment that you have received at a hospital .	 Full cover	 Full cover
Out-patient surgical procedures Surgical procedures that do not require in-patient or day-patient treatment.	 Full cover	 Full cover
Advanced diagnostic tests MRI and CAT (CT) scans performed on the advice of a medical doctor and PET scans performed on the advice of a specialist . Your medical referral letter will be required. We will pay for one consultation only to obtain the results of the diagnostic test .	 Full cover	 Full cover
Complimentary treatments Treatment by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist on the advice of a medical doctor . Your medical referral letter will be required for any treatment by a chiropractor, osteopath, chiropodist or podiatrist. If your condition is (or becomes) a chronic condition and ongoing treatment is aimed at maintaining it rather than curing it, no further payments will be made. Cover is limited to the maximum number of sessions shown per period of cover in respect of all treatment types. Treatment must be performed by a medical practitioner .	 Cover for up to 10 sessions per period of cover	 Cover for up to 15 sessions per period of cover
Hormone replacement therapy When prescribed by a medical doctor following your diagnosis with premature ovarian failure (i.e. loss of ovarian function before the age of 40).	 Cover for a maximum period of 12 months from the date of diagnosis	 Cover for a maximum period of 18 months from the date of diagnosis
Traditional Chinese medicine Cover is limited to the maximum number of sessions shown per period of cover . Treatment must be performed by a medical practitioner .	 Cover up to US\$50 or AED184 per session , up to a maximum of 15 sessions	 Cover up to US\$50 or AED184 per session , up to a maximum of 20 sessions
Physiotherapy Medically necessary physiotherapy when you have been referred on the advice of your medical doctor to a physiotherapist who is registered to practice physiotherapy in the country where the treatment is administered. You must send us your medical referral letter in support of your claim . If you need more sessions after your first 6 sessions of physiotherapy, your doctor must provide a progress report for us to assess your claim further. We will not pay for any physiotherapy that we have not pre-authorised. If your condition is (or becomes) a chronic condition and ongoing treatment is aimed at maintaining it rather than curing it, no further payments will be made.	 Full cover	 Full cover









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Cover	Silver	Gold
<p>Well-being benefits Important notes:</p> <ul style="list-style-type: none"> All claims within this section are on a reimbursement-only basis. Please see the 'If you need to make a claim' section of this agreement. 		
<p>Preventive health and well-being Preventive health checks and tests for adults, including:</p> <ul style="list-style-type: none"> health screens (e.g. tests for cholesterol, high blood pressure, diabetes, anaemia, lung/kidney/liver function, cardiac risk) Papanicolaou (PAP) test mammogram, prostate cancer, and colon cancer screens flu jabs medically necessary vaccinations hearing test eye examination 	<p> Cover up to US\$300 or AED1,101 per period of cover</p>	<p> Cover up to US\$550 or AED2,019 per period of cover</p>
<p>Preventive health screenings Preventive screening for diabetes and other screenings as stipulated by the DHA every three years for insured persons aged 30 and over, or every year for insured persons aged 18 and over who are considered to be high risk.</p>	<p> Full cover</p>	<p> Full cover</p>
<p>Well-child benefit Developmental check-ups for children up to six years old.</p>	<p> Full cover</p>	<p> Full cover</p>
<p>Child vaccinations Essential vaccinations and inoculations for children up to six years old, as stipulated in the DHA policies and its updates.</p>	<p> Full cover</p>	<p> Full cover</p>
<p>Chronic conditions</p> <p>Cover is provided in conjunction with the benefits listed elsewhere in the table of benefits for your plan type, and is subject to the limits for those benefits.</p> <p>If, for example, you are claiming for psychiatric benefits, then this would be covered under the psychiatric and psychotherapy treatment benefit section. The lifetime limit, benefit limits, maximum number of days of treatment, and maximum number of consultations for this particular benefit section will apply.</p> <p>There are three exceptions:</p> <ul style="list-style-type: none"> Physiotherapy is excluded when it is intended to treat a chronic condition Medical aids that form part of the care of a chronic condition (e.g. an insulin pump to inject insulin) are excluded. Any claims relating to congenital conditions or hereditary conditions that are chronic will not be eligible under this benefit (however, they may be covered under the congenital conditions or hereditary conditions benefit) 		
<p>Rehabilitation treatment Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorisation for this benefit. 		
<p>Rehabilitation treatment you receive as an in-patient, carried out under the control and supervision of a specialist in a recognised rehabilitation hospital or unit, and only when it immediately follows in-patient treatment for illness or injury covered by your plan.</p> <p>This benefit is payable only when the admission takes place on the written recommendation of your treating specialist and the admission must take place immediately following your discharge from hospital.</p>	<p> Cover for up to 15 days per medical condition</p>	<p> Cover for up to 30 days per medical condition</p>










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Cover	Silver	Gold
<p>Home nursing costs Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorisation for this benefit. 		
<p>The medical services of a qualified nurse to treat you in your own home when it is medically necessary and relates directly to an illness or injury covered by your plan.</p>	<p>○ Cover for up to 12 weeks per medical condition</p>	<p>○ Cover for up to 12 weeks per medical condition</p>
<p>Lifetime care Important notes:</p> <ul style="list-style-type: none"> You must obtain pre-authorisation for all benefits included in this section. 		
<p>Lifetime limit for all lifetime care The overall maximum limit to the amount you can claim during your lifetime for all benefits within the lifetime care benefit section.</p>	<p>US\$50,000 or AED183,500</p>	<p>US\$100,000 or AED367,000</p>
<p>Hospice and palliative care On diagnosis of a terminal medical condition covered by your plan, all costs for treatment received on the advice of a medical practitioner or specialist for the purpose of offering relief of symptoms. This includes all hospital or hospice accommodation, and nursing care by a qualified nurse.</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>
<p>Artificial life maintenance Treatment you require after you have already been on artificial life maintenance for 8 weeks.</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>
<p>Persistent vegetative state and neurological damage Treatment you require after you have been in hospital for 8 weeks for permanent neurological damage or if you are in a persistent vegetative state.</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>	<p>○ Cover up to the lifetime limit for lifetime care</p>
<p>Optical care Important notes:</p> <ul style="list-style-type: none"> You are eligible for the benefits in this section only if they have been selected by your employer. All claims within this section are on a reimbursement-only basis. Please see the 'If you need to make a claim' section of this agreement. 		
<p>We will pay for an annual optical test. Within this benefit, we will pay for lenses and contact lenses only upon a change of prescription.</p> <p>We do not pay for LASIK eye surgery or any other surgical correction of short-sightedness (myopia), long-sightedness (hyperopia) or irregular-shaped cornea (astigmatism).</p> <p>The optical care benefit is limited to US\$200 or AED734, or US\$500 or AED1,835, depending on which option your employer has selected. You are not eligible for cover if neither option is selected.</p>	<p>○ Cover up to US\$200 or AED734 per period of cover (only if selected by your employer)</p> <hr/> <p>○ Cover up to US\$500 or AED1,835 per period of cover (only if selected by your employer)</p>	<p>○ Cover up to US\$200 or AED734 per period of cover (only if selected by your employer)</p> <hr/> <p>○ Cover up to US\$500 or AED1,835 per period of cover (only if selected by your employer)</p>

Key  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Silver	Gold
<p>Dental costs Important notes:</p> <ul style="list-style-type: none"> You are eligible for certain benefits in this section only if they have been selected by your employer. All dental treatment must be carried out by a dentist in a hospital emergency room or dental surgery. Treatment for damaged crowns, dentures, bridge work or false teeth is only covered under the Dental Plus benefit. We do not cover orthodontic consultations or treatment of any kind. 		
<p>Emergency restorative treatment you receive as an in-patient In-patient treatment required to restore sound and natural teeth following an accident covered by your plan, provided that treatment is received within 15 days of the accident.</p>	 Full cover	 Full cover
<p>Emergency restorative treatment you receive as an out-patient Out-patient treatment required to treat or replace sound and natural teeth which are lost or damaged following an accident, provided that treatment is received within 72 hours of the accident.</p>	 Cover up to US\$40,872 or AED150,000 per period of cover	 Cover up to US\$40,872 or AED150,000 per period of cover
<p>Dental Basic We will pay for the following basic dental costs:</p> <ul style="list-style-type: none"> screening (e.g. the checking for or the assessment of any diseased, missing, and filled teeth, including X-rays where necessary) twice per year scaling, polishing, and sealing twice per year fillings (both composite and amalgam) simple extractions root canal treatment <p>This benefit is optional on the Silver plan. You are not eligible for cover under this benefit if not selected by your employer.</p> <p>All claims within this section are on a reimbursement-only basis. Please see the 'If you need to make a claim' section of this agreement.</p>	 Cover up to US\$1,000 or AED3,670 per period of cover , subject to 10% co-insurance (only if selected by your employer)	 Cover up to US\$1,500 or AED5,505 per period of cover
<p>Dental Plus We will pay for the following advanced dental costs:</p> <ul style="list-style-type: none"> denture repair full/partial dentures dental bridges crowns, inlays, and onlays dental implants <p>This benefit is optional on the Silver and Gold plans. You are not eligible for cover if neither option is selected by your employer.</p> <p>All claims within this section are on a reimbursement-only basis. Please see the 'If you need to make a claim' section of this agreement.</p>	 Cover up to US\$1,000 or AED3,670 per period of cover , subject to 10% co-insurance (only if selected by your employer)	 Cover up to US\$1,500 or AED5,505 per period of cover , subject to 20% co-insurance (only if selected by your employer)

Key  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Silver	Gold
<p>Maternity costs Important notes:</p> <ul style="list-style-type: none"> • You are eligible for certain benefits in this section only if they have been selected by your employer. • Dependant children included in your plan are not eligible for these benefits. • We do not cover the treatment of any newborn child born following assisted reproduction (e.g. IVF) in the event of the birth occurring within 36 weeks of conception. • Any charges incurred during normal childbirth (including a planned caesarean section) will be paid from the routine maternity care and childbirth benefit. • We do not cover pregnancy testing, or pre-natal classes and doulas. • We do not cover termination of pregnancy or any treatment or investigations that arise as a result of complications relating to termination of pregnancy. <p>Routine maternity care and childbirth We will pay for the following routine maternity costs:</p> <ul style="list-style-type: none"> • pre-natal tests and examinations • post-natal treatments and examinations • natural childbirth • childbirth by planned caesarean section • home birth, where a midwife is present • supplements and vitamins as recommended by a medical doctor <p>The limits shown for this benefit apply to each pregnancy, regardless of the number of children born.</p> <p>Any hospital or birthing centre accommodation costs will be limited to the cost of a standard hospital room.</p> <p>The routine maternity care and childbirth benefit on the Silver plan is limited to US\$2,725 or AED10,000 as standard. The benefit limit is extended to US\$5,000 or AED18,350, US\$7,000 or AED25,690, or \$10,000 or AED36,700 if selected by your employer.</p> <p>The group of services itemised in the paragraph below will be fully covered. Anything we pay for these services does not count toward the routine maternity care and childbirth benefit limit for the Silver and Gold plans.</p> <p>Full blood count and platelets, mid-stream urine tests and analysis, blood group, Rhesus stats and antibodies, VDRL, rubella serology, HIV, hepatitis C (for high-risk patients only), glucose tolerance (for high-risk patients only), full blood sugar, 3 prenatal ultrasound scans, and 8 visits to a Primary Healthcare Centre, or any provider within your Neuron network.</p>	<ul style="list-style-type: none">  Cover up to US\$2,725 or AED10,000 per pregnancy <hr/> <ul style="list-style-type: none">  Cover up to US\$5,000 or AED18,350 per pregnancy (only if selected by your employer) <hr/> <ul style="list-style-type: none">  Cover up to US\$7,000 or AED25,690 per pregnancy (only if selected by your employer) <hr/> <ul style="list-style-type: none">  Cover up to US\$10,000 or AED36,700 per pregnancy (only if selected by your employer) 	<ul style="list-style-type: none">  Cover up to US\$15,000 or AED55,050 per pregnancy
<p>Complications of pregnancy In-patient or day-patient treatment necessary as a direct result of a complication of pregnancy.</p> <p>We do not provide cover under this benefit arising from a pregnancy established through assisted reproduction (e.g. IVF) until after the standard 12-week scan, irrespective of how long you have been covered by the plan.</p>	<ul style="list-style-type: none">  Cover up to US\$40,872 or AED150,000 per period of cover 	<ul style="list-style-type: none">  Full cover
<p>Childbirth necessitating an emergency surgical procedure Surgeons', anaesthetists' and theatre fees for childbirth that necessitates an emergency surgical procedure and any additional accommodation charges incurred as the result of the surgical procedure. This includes childbirth by emergency caesarean section.</p>	<ul style="list-style-type: none">  Cover up to US\$2,725 or AED10,000 per pregnancy 	<ul style="list-style-type: none">  Full cover

Key ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Silver	Gold
<p>Maternity costs (continued) Important notes:</p> <ul style="list-style-type: none"> • You are eligible for certain benefits in this section only if they have been selected by your employer. • Dependant children included in your plan are not eligible for these benefits. • We do not cover the treatment of any newborn child born following assisted reproduction (e.g. IVF) in the event of the birth occurring within 36 weeks of conception. • Any charges incurred during normal childbirth (including a planned caesarean section) will be paid from the routine maternity care and childbirth benefit. • We do not cover pregnancy testing, or pre-natal classes and doulas. • We do not cover termination of pregnancy or any treatment or investigations that arise as a result of complications relating to termination of pregnancy. 		
<p>Cover for newborn babies We will pay the following costs during your baby's first 90 days of life:</p> <ul style="list-style-type: none"> • treatment your newborn baby receives as an in-patient or day-patient (including treatment of birth defects and congenital or hereditary conditions) • accommodation costs for one parent to stay with the newborn baby if the baby is hospitalised • any hospital accommodation costs for the newborn baby • basic newborn healthcare (physical examination, Vitamin K, hepatitis B vaccine, BCG vaccine, one hearing test, and blood tests for PKU, congenital hypothyroidism and G6PD) <p>The limits shown apply to each pregnancy, regardless of the number of children born.</p>	<p>○ Cover up to US\$40,872 or AED150,000 per pregnancy</p>	<p>○ Cover up to US\$100,000 or AED367,000 per pregnancy</p>
<p>Expat benefits Important notes:</p> <ul style="list-style-type: none"> • You are eligible for certain benefits in this section only if you have selected them and they are stated on your certificate of insurance. • You must obtain pre-authorisation for all benefits included in this section. • All claims under this benefit are on a reimbursement-only basis. Please see the 'If you need to make a claim' section of this agreement. 		
<p>24-hour medical assistance helpline If you have a medical emergency which requires immediate medical assistance, you must contact our 24-hour helpline (provided by CEGA) at +44 (0) 1243 621155 or william.russell@cegagroup.com.</p>	<p>○ Full cover</p>	<p>○ Full cover</p>
<p>Medevac Basic If you (or any child covered by the newborn benefit within its first 90 days of life) have a life-threatening or limb-threatening condition covered by your plan which requires immediate in-patient treatment that cannot be adequately provided locally, the Assistance Service will arrange for you to be moved by air and/or by surface transportation, to the nearest hospital within your area of cover where appropriate medical treatment is available. We do not cover any other costs under this benefit such as hotel accommodation charges. We do not cover emergency evacuation to, from or within the USA. The Assistance Service retains the absolute right to decide whether your medical condition is eligible for evacuation, where you are evacuated to and the means and method of the evacuation.</p>	<p>○ Full cover</p>	<p>○ Full cover</p>
<p>Return airfare Following an emergency evacuation covered by your plan, we will pay for your economy return airfare to your country of residence.</p>	<p>○ Full cover</p>	<p>○ Full cover</p>









Key  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Silver	Gold
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Expat benefits (continued)

Important notes:

- **You** are eligible for certain benefits in this section only if **you** have selected them and they are stated on **your certificate of insurance**.
- **You** must obtain pre-authorisation for all benefits included in this section.
- All **claims** under this benefit are on a reimbursement-only basis. Please see the 'If **you** need to make a **claim**' section of this agreement.

<p>Expenses of a companion</p> <p>The transportation costs of another person to accompany you on your emergency evacuation, and their economy class ticket back. If it is not possible for them to accompany you on your medical evacuation because of the method of evacuation, we will pay either for their economy class round-trip airfare on a scheduled flight, or their suitable round-trip surface transportation, whichever is the most appropriate.</p> <p>If your companion is then staying with you while you are hospitalised following your evacuation, we will pay towards the costs of their hotel accommodation up to US\$96 or AED352 per night on the Silver plan, and US\$250 or AED918 per night on the Gold plan (limited to a maximum of 15 nights per period of cover).</p>	 Full cover	 Full cover
<p>Compassionate home visit</p> <p>If a close family member dies during your period of cover and after you have been insured by your plan for a continuous period of 12 months, we will pay for your round-trip economy airfare to attend the funeral. Your travel must take place within 28 days of the date of death.</p>	 Lifetime limit of one claim per insured person	 Lifetime limit of one claim per insured person
<p>Repatriation of mortal remains</p> <p>If you die as the result of a condition that is covered by your plan while you are outside your country of nationality, we will pay for your body or ashes to be transported to your country of nationality or country of residence.</p> <p>This benefit is not available if a claim is made for burial or cremation at the place where you died.</p>	 Full cover	 Full cover
<p>Burial or cremation</p> <p>If you die as the result of a condition that is covered by your plan while you are outside your country of nationality, we will pay for you to be buried or cremated at the place where you died.</p> <p>This benefit is not available if a claim is made under the repatriation of mortal remains benefit.</p> <p>We do not provide cover under this benefit if you die in your country of nationality.</p> <p>We do not provide cover under this benefit for the costs of a religious practitioner.</p>	 Cover up to US\$1,600 or AED5,872	 Cover up to US\$1,600 or AED5,872

Key  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Silver	Gold
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Expat benefits (continued)

Important notes:

- **You** are eligible for certain benefits in this section only if **you** have selected them and they are stated on **your certificate of insurance**.
- **You** must obtain pre-authorisation for all benefits included in this section.
- All **claims** under this benefit are on a reimbursement-only basis. Please see the 'If **you** need to make a **claim**' section of this agreement.

Medevac Plus

The following benefits apply in addition to those under the Medevac Basic benefit.


Evacuation if **you** (or any child covered by the newborn benefit within its first 90 days of life) need **advanced imaging** or cancer **treatment** such as radiotherapy or chemotherapy that cannot be adequately provided locally.


All eligible evacuations will include repatriation to **your country of nationality** if it is within **your area of cover**, or to **your country of residence**. We do not cover emergency evacuation or repatriation to, from or within the USA.

If **you** request repatriation to **your country of nationality** or to **your country of residence**, it may, in some cases, not be appropriate immediately due to **your** medical condition. In such cases, **we** will first evacuate **you** to the nearest place within **your area of cover** where appropriate **treatment** is available. Once **you** have been stabilised, **we** will then repatriate **you** to **your country of nationality** if it is within **your area of cover**, or **your country of residence**.

If **you** are evacuated to a country which is not **your country of residence** and not **your country of nationality**, and **you** do not have anyone to accompany **you**, **we** will pay the economy class round-trip airfare to have one companion flown from anywhere in the world to be with **you** while **you** receive **your treatment**. **We** will also pay up to US\$150 per day (for a maximum of 30 days per **period of cover**) towards their hotel accommodation expenses whilst **you** have **your treatment**, or until the date on which **you** return to your **country of nationality** or your **country of residence** (whichever is the sooner).

Cover is only available if the Medevac Plus option is selected by **your employer**.

 Full cover (only if selected by **your employer**)

 Full cover (only if selected by **your employer**)

What you are not covered for

The following are not covered by **your plan**, as well as any exclusions stated within the **table of benefits**. Other benefits, as stated within the **table of benefits**, may also be restricted or excluded depending on **your plan type**.

All conditions, tests, **treatments** or increased **treatment** costs **you** incur because of complications that occur directly or indirectly as a consequence of **treatment** of any excluded condition will also not be covered.

We will also not pay for the fees and charges listed below. **You** will be responsible for them.

- fees for the completion, or providing of, claim forms or any other medical reports or forms such as **medical referral letters**, even if **we** have requested them
- bank charges incurred as a result of **us** transferring money
- losses **you** may incur due to fluctuations in exchange rates
- charges incurred as the result of payment errors that arise as the result of **you** having provided **us** with incorrect information
- administration, registration, or cancellation fees charged by **hospitals, doctors**, or other providers of medical services
- any charges made by **your** bank or credit card company

Addictive conditions or disorders, and alcohol, drug, and solvent abuse

You are not covered for **treatment** related to:

- addictions (such as alcohol or drug addiction) or substance abuse (such as alcohol, drug or solvent abuse)
- any illness or injury needed directly or indirectly as a result of any such abuse or addiction
- any illness or injury needed directly or indirectly as a result of being under the influence of any substance (such as alcohol, drugs or solvents)

Allergy testing and/or desensitisation

You are not covered for **treatment** related to:

- allergy testing by hair analysis
- allergy desensitisation or food neutralising injections

We will only pay for patch testing if **you** have been referred by a **medical doctor** and this is limited to one patch testing investigation over the lifetime of **your plan**. **Your medical referral letter** will be required.

Alternative treatment and therapies

You are not covered for alternative **treatments** and therapies, including, but not limited to, aqua physiotherapy, bone-setting, colonic irrigation, hydrotherapy, Intervertebral Differential Dynamics (IDD), kinesiology, naturotherapy, Ayurveda and massage therapy.

Artificial life maintenance

You are not covered for **artificial life maintenance**, other than any benefit **you** are eligible for under the lifetime care benefit.

Birth control, sexual problems and gender reassignment

You are not covered for **treatment** directly or indirectly arising from or connected with:

- contraception or sterilisation
- sexual problems (including impotence and decreased libido)
- gender reassignment

Chemical exposure and contamination

You are not covered for **treatment** costs directly or indirectly related to **treatment** for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.

Circumcision

You are not covered for **treatment** related to circumcision, unless it is required for **treatment** of an **acute medical condition** covered by **your plan**.

Convalescence, rehabilitation, nursing homes, and health spas/hydros

You are not covered for:

- **hospital** accommodation if the reason **you** are hospitalised is for the purpose of convalescence, **rehabilitation** or supervision
- relaxation or rest **treatments**, or **treatments** in nature cure clinics, health spas and health hydros
- private beds registered as nursing homes attached to such establishments or a **hospital** where the **hospital** has effectively become **your** home or permanent abode

Other than **treatment you** are eligible for under the **rehabilitation treatment** benefit.

Cosmetic surgery and treatment

You are not covered for investigations or **treatment** related to:

- cosmetic or aesthetic **treatment** to enhance **your** appearance, even when medically prescribed
- the removal of fat or surplus tissue
- breast enlargement or reduction
- sclerotherapy for spider veins, **treatment** of superficial varicose veins
- Botox, dermal fillers, or **treatment** of vitiligo or any skin pigmentation disorder

Criminal activity

You are not covered for **treatment** arising from or related to injuries sustained while **you** are engaged in a criminal, illegal or unlawful act.

Dietitian

You are not covered for **treatment** or advice by a dietitian or nutritionist. Please note however this may be covered following a diagnosis of cancer. Please see the dietitian benefit within the cancer **treatment** section of the **table of benefits**.

Experimental drugs and treatments

You are not covered for **treatment** which is experimental, or has not been proven to be effective. This includes, but is not limited to:

- **treatment** that is provided as part of a clinical trial
- **treatment** that is not consistent with internationally recognised guidelines. Internationally recognised guidelines means guidelines issued by the Dubai Health Authority, the United Arab Emirates Ministry of Health, the US Federal Drugs Administration, the European Medicines Agency or the UK National Institute for Health and Clinical Excellence (NICE) in the UK

Eyesight

You are not covered for:

- **treatment** to correct **your** eyesight, such as laser **treatment**, refractive keratotomy and photorefractive keratotomy
- spectacles, and other visual aids, **treatment** of strabismus (squint) or amblyopia (lazy eye)
- sight tests - please note however these may be covered under the well-being benefits section of the **table of benefits**

Please note that some or all of the above may be covered by the optical care benefit or, in a medical emergency, under the emergency optical or auditory **treatment** benefit.

Foetal surgery

You are not covered for surgery undertaken with the intention of ruling out any foetal anomaly.

Genetic testing or genetic engineering

You are not covered for genetic testing or genetic engineering, other than **treatment you** are eligible for under the cancer genome tests benefit within the cancer **treatment** benefit section of the **table of benefits**.

Hearing

You are not covered for:

- **treatment** for or arising from deafness caused by maturing or ageing
- **treatment** for or arising from deafness caused by a **congenital condition** if either the abnormality was diagnosed, or **you** were showing signs or symptoms of the abnormality, before **your date of entry** - please note however that this may be covered for newborn children during their first 90 days of life under the newborn babies benefit
- hearing aids
- hearing tests (unless covered under **your plan** in the well-being

benefit section of the **table of benefits**)

Please note that some or all of the above may be covered in a medical emergency under the emergency optical or auditory **treatment** benefit.

Infertility, IVF and assisted reproduction

You are not covered for:

- testing or diagnosis related to infertility
- infertility **treatment, assisted reproduction** (e.g. IVF **treatment**), including establishing pregnancy

Learning and educational difficulties

You are not covered for learning and educational difficulties, including, but not limited to, dyslexia and speech disorders.

Nasal septum deviation

You are not covered for **treatment** related to nasal septum deviation and nasal concha resection.

Persistent vegetative state and neurological damage

You are not covered for **treatment** received after:

- **you** have been in a **vegetative state** for a period of eight weeks
- **you** have sustained permanent neurological damage and remained in **hospital** for a period of eight weeks

Except for any **treatment you** are eligible for under the lifetime care benefit.

Professional sports and motorised racing as an amateur or a professional

You are not covered for **treatment** for an illness or injury related to:

- participation, to include training for or practising for, in any kind of professional sport or professional racing (by professional **we** mean sport where **you** are being paid to participate)
- participation, to include training for or practising for, in any kind of racing (whether amateur or professional) which involves the use of a motorised vehicle

Scalp conditions

You are not covered for:

- **treatment** specifically related to scalp conditions, including, but not limited to, alopecia
- wigs (please note however this may be covered following chemotherapy – see the wigs benefit of the **table of benefits**)

Search and/or rescue

You are not covered for:

- search and/or rescue operations, including, but not limited to, mountain rescue or rescue from ski slopes or pistes
- evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht

Second opinions or duplicate tests

You are not covered for second or subsequent opinions from

a **medical doctor, medical practitioner** or **specialist** or for duplicate tests for the same condition.

Self-inflicted injuries

You are not covered for **treatment** of self-inflicted injuries or **treatment** of any injury or illness directly or indirectly caused by self-inflicted injuries.

Sleep disorders

You are not covered for **diagnostic tests** for or **treatment** of any sleep related disorder, including, but not limited to, insomnia, snoring and sleep apnoea.

Stem cell harvesting

You are not covered for stem cell harvesting other than prior to a stem cell transplant, or any **treatment** undertaken in anticipation of, prior to, or following such harvesting.

Sundry medical supplies

You are not covered for non-prescribed items such as hot and cold packs and support bandages, unless these are required as a result of **treatment** received during a medical emergency.

Travel costs

You are not covered for travel costs including airfares and hotel accommodation, unless specifically covered under the expat benefits section of the **table of benefits**.

Treatment by a related party

You are not covered for **treatment** provided by and/or under the control of and/or on referral from:

- any family member, including, but not limited to, a spouse, partner, parent, brother, sister, child, grand-parent, grand-child, uncle or aunt
- any **medical services provider, medical practitioner** or **specialist** where the **insured person** has a financial interest and/or a professional interest, including, but not limited to, **employees, employers, consultants** and owners

Vitamins, dietary supplements, natural substances, and creams

You are not covered for commercially available substances that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic substances, moisturisers, oils, creams, or other pharmaceutical products, unless medically necessary or specified under the routine maternity care and childbirth benefit within the maternity costs benefits section of the **table of benefits**.

War and terrorism

You are not covered for **treatment** arising directly or indirectly from war, foreign enemy hostility, terrorism, rebellion, civil war, revolution, military coup, riot, strike, martial law, state of seige or attempted overthrow of a government, unless **you** are an **innocent bystander** in a country or region that the British Foreign & Commonwealth Office has not advised its citizens to leave.

Weight-related conditions and eating disorders

You are not covered for investigations or **treatment** related to:

- obesity, or which is necessary because of obesity
- weight monitoring or control, such as slimming classes, aids and drugs
- bariatric surgery, or complications resulting from bariatric surgery
- eating disorders of any kind, such as anorexia nervosa or bulimia

If you need to make a claim

If **you** need to seek medical advice or **treatment**, please follow these steps:

1. Contact Neuron

You can only claim for **treatment** that is covered under the terms of **your plan**. Before **you** undergo a course of **treatment** we strongly recommend that **you** call Neuron, who can advise **you** whether the proposed **treatment** will be covered by **your plan**. The contact details for Neuron can be found toward the beginning of this **agreement**.

2. Check that the medical provider you want to use is part of the network you are entitled to use

The name of the Neuron network **you** are entitled to use is as stated on **your certificate of insurance** and on **your Neuron network card**. To check that the **hospital, out-patient** clinic or pharmacy **you** want to use is part of the Neuron network on **your card**, please go to neuron.ae.

If the provider **you** intend to use is within the Neuron network stated on **your Neuron network card** please go to step 3.1 below

If the provider **you plan** to use is not within the Neuron network stated on **your Neuron network card**, please go to step 3.2 below.

Please also refer to the 'General points relating to making a **claim**' heading at the end of this section of the **agreement**.

3.1. If the medical provider is within the Neuron network you are entitled to use

When **you** attend **your** appointment, please present **your Neuron network card** to the **medical network provider** who will also ask **you** to show another form of photographic ID such as **your** passport, and/or Emirates ID card, which **you** must provide before **treatment** can take place.

Certain procedures and tests require authorisation by Neuron before the clinic or **hospital** can proceed with them. All **medical network providers** within the Neuron network are aware of these requirements and will contact Neuron directly for the necessary pre-authorisation.

If your plan has an excess

If **your plan** has an **excess**, **you** must pay the **excess** amount to the **medical network provider** in respect of each **doctor's** consultation, or each visit to a **dentist**.

The **medical network provider** will submit the invoices for **your** consultation and **treatment** (less the **excess** amount **you** have paid if applicable) to Neuron for settlement.

If **your claim** is for **treatment** that is not covered by **your plan** **you** will be invoiced for the ineligible costs that Neuron has settled.

Our right to withdraw the Neuron service at any time

We reserve the right to withdraw the Neuron service from **you** at any time. If **we do**, **you** must immediately return to **us your Neuron network card** and the **Neuron network card(s)** issued to each of **your** dependants.

3.2 If the medical provider is not within the Neuron network you are entitled to use

Customers with a Silver or Gold plan

If **you** have **your treatment** at a **medical services provider** in the UAE that is not listed as being in **your** network, an **out-of-network penalty** will apply. However, if **you** have eligible **treatment** outside of the UAE, no **out-of-network penalty** will apply.

The **out-of-network penalty** will be 20% if **you** have the **General Plus network**, and 25% if **you** have the **Comprehensive network**.

Customers with a Dubai Primary Benefits plan

There is no cover for **treatment** **you** receive outside the **Ultra-Restricted network**. **You** will only be reimbursed for eligible **treatment** **you** receive within the **Ultra-Restricted network**.

If you are making a claim for in-patient or day-patient treatment

All **in-patient** and **day-patient hospital treatment** must be pre-authorised by more than 48 hours in advance either by Neuron if **you** are in the UAE, or by the **Assistance Service** if **you** are travelling outside the UAE.

Please contact Neuron or the **Assistance Service** as soon as **you** know **you** need to have **in-patient** or **day-patient treatment** so they can contact the **hospital** to obtain the necessary paperwork to enable them to assess **your claim**.

You will need to complete a claim form and **you** may be required to complete a consent form for the **hospital** to release details to Neuron or the **Assistance Service**. Once Neuron or the **Assistance Service** have received all information required from the **hospital** and **yourself** (to include any additional information that may be requested) they will advise **you** if the proposed **treatment** will be covered by **your plan**.

If **you** are admitted to **hospital** in an emergency and it is not reasonably possible for **you** to contact Neuron or the **Assistance Service** in advance of **your** admission, **your claim** will be considered, provided **you** contact them within 24 hours of **your** admission. If **you** do not contact them within 24 hours, **your claim** may be declined or subject to 20% **co-insurance**.

If you are making a claim for out-patient treatment

Although most **out-patient treatment** does not need to be pre-authorised in advance by Neuron or the **Assistance Service**, we recommend that **you** do contact them before undergoing any **treatment** to ensure that the **treatment** is covered by **your plan**.

How to claim back your eligible treatment costs

If **you** are claiming for a medical condition, **you** will need to download a claim form from Neuron's website. Please go to neuron.ae to download the form.

Please complete Section A of the claim form and sign the Patient's Consent and Declaration section at the end of the form. Please take the claim form with **you** when **you** visit **your doctor** and ask him or her to complete and sign Section B and C of the claim form.

Scan the completed claim form and the fully itemised invoices for the **treatment** **you** have received, and send to reimbursement.

claims@neuron.ae.

Neuron can only reimburse **your claim** when they have fully itemised invoices which give a breakdown of the **treatment** and medical services **you** have received, and any drugs **you** have been prescribed.

Please retain **your** original invoices for 12 months. **Your** original claim form and invoices may be requested for auditing purposes.

Claim forms are not required however when **you** are claiming for the following benefits:

- Well-being **claims**: if **you** are claiming for the well-being benefit please send Neuron the fully itemised invoices for which **you** are claiming reimbursement, together with **your** bank account details.
- Compassionate home visit **claims**: if **you** are claiming for the compassionate home visit benefit please send Neuron a copy of the death certificate of **your close family member**, together with a copy of the invoice for **your** round-trip airfare, stating the class of travel, and **your** bank account details.

Claims for which a medical referral letter is required

If **you** are claiming for **out-patient** physiotherapy, any **treatment** by a chiropractor, osteopath, chiropodist or podiatrist, **out-patient** psychiatric or psychotherapy **treatment**, or an MRI or CAT (CT) scan **you** must also send Neuron **your medical referral letter**. If **you** are claiming for a PET scan, **you** must also send Neuron **your specialist's medical referral letter**.

Supplying the information required to process your claim

Neuron can accept the information required to process **your claim** via email. Simply, scan in PDF format **your** itemised invoices, receipts, **medical referral letter** (when required) and **your** fully completed claim form and email them all to reimbursement.claims@nneuron.ae. Please always retain the original copies of everything for a period of 12 months as Neuron reserve the right to receive these documents before they assess **your claim**. Neuron may also require them at any time for auditing purposes. Or, **you** can send the information required to process **your claim** by post.

You must submit **your claim** within 6 months of **your treatment date**, unless it was not reasonably possible for **you** to submit the **claim** within this time. Neuron will not pay any invoices they receive more than 12 months after **your treatment date**.

Neuron will not pay fees charged by a **medical practitioner**, or anyone else, for completing a claim form.

If you have optional USA cover and you seek treatment in the USA

All **treatment you** receive in the USA must be pre-authorised in advance by the **Assistance Service**. Any **treatment** in the USA that has not been pre-authorised will not be covered.

If a local agent is instructed by the **Assistance Service** to arrange the billing and/or cost adjustment of **your medical treatment** expenses in the USA, any fees charged by the local agent will be deducted from the USA benefit limit available under **your plan**, as stated in the '**Your area of cover**' section of this **agreement**.

Paying your claims

Neuron will deduct any **excess** and/or **co-insurance** amount, as well as any other ineligible items, and then settle the balance to **you** by cheque (available in United Arab Emirates dirham only) or bank transfer. If **you** provide incorrect payment details and **we** cannot recover the payment, **we** will not make the payment again to **you**.

Neuron will only make payment to **you**.

Exchange rates

Neuron will settle **your claim** in the currency in which **you** pay **your premium** unless **you** instruct otherwise. If they have to make a currency conversion, they will use the historic exchange rate (provided by xe.com) applicable on the date of each separate invoice **you** submit. However if they have placed a Guarantee of Payment they will use the exchange rate applicable on the date they placed the guarantee.

Excesses, co-insurance, and benefit limits

The **excess** shown on **your certificate of insurance** and **your Neuron network card** is the amount **you** will have to pay towards the cost of **your treatment**.

If **your plan** has an **excess** and/or **co-insurance**, **you** must pay this before leaving the **medical services provider**.

The total **excess** and **co-insurance** for **out-patient treatment** received in the UAE is subject to a maximum of 20% of the total **treatment** cost. Details of this are given on **your Neuron network card**.

If **your plan** has an **excess** and the benefit **you** are claiming for has **co-insurance** and/or limits, Neuron will apply the **co-insurance** first, then the **excess**, then the limit.

If **your claim** is for the **treatment** of a **chronic condition**, AIDS/HIV, or for **out-patient** follow-up consultations and/or tests for cancer and the **treatment** continues into a new **period of cover**, Neuron will treat it as a new **claim**. In these circumstances Neuron will re-apply the **excess** at **your plan renewal date** and each subsequent **plan** renewal until the **claim** is finished.

If **your claim** is in respect of the well-being benefits, **your excess** will be applied once per **period of cover**.

The **excess** will also be applied to **your claim** in respect of each visit **you** make to a **dentist**.

General points relating to making a claim

Neuron may need to ask for additional information to enable them to assess **your claim**, such as further medical reports or tests, or an independent medical examination. If **you** do not agree to supply them with any reasonable additional medical information they ask for, Neuron will not be able to assess **your claim**.

Neuron may request additional medical information to enable them to assess **your claim**, such as medical reports or tests. These must be provided at **your** own expense. Neuron may also request an independent medical examination. If **you** do not agree to supply Neuron with additional medical information that they reasonably request, they will not be able to assess **your claim**.

Neuron will not pay for **treatment** which in their opinion is inappropriate based on established medical and clinical practice and they are entitled to conduct a review of **your treatment** when it is reasonable for them to do so.

If **you** require ongoing **treatment** Neuron may ask for further medical information and if they do, the cost of providing this information must be borne by **you**. Neuron is unable to return original documents such as invoices or medical letters, but they will send **you** copies upon request.

If Neuron or the **Assistance Service** pre-authorise costs which subsequently turn out to have been related to a condition which is not covered by **your plan**, **you** will be responsible for all the costs incurred, and if Neuron has made any settlement on **your** behalf, **you** will be responsible for repaying Neuron the amount they have paid.

Illness or injury caused by a third party

If **you** are claiming for an illness or injury that was caused by some other person or organisation (a third party) **you** must let **us** know in writing straight away, or tell **us** on **your** claim form. **We** will then pay benefit in accordance with the terms of this **agreement** provided that **you** take all necessary steps **we** ask **you** to take to assist **us** in recovering **our** costs from the person or organisation at fault (such as through their insurance company) the cost of the **treatment** paid for by **us**, plus interest, at **your** own expense.

If **you** pursue a personal claim for damages against the third party, **you** must provide **us** with the full name and address of the solicitor handling the action. **We** will then contact the solicitor to register **our** interest and seek to recover **our** own costs, plus interest, in addition to any damages that **you** may recover or be awarded. **We** reserve the right to appoint **our** own solicitor to act on **your** behalf in this matter and to take over the conduct of the action.

If **you**, or any **insured person**, are able to recover from the third party (whether or not through legal action) compensation that includes any **treatment** costs **we** have paid, **you** must repay that amount to **us**. Any interest that **you** or any **insured person** may also have been awarded that relates to the recovered **treatment** costs **we** have paid for must also be repaid to **us**. If costs which subsequently turn out to have been related to a condition which is not covered by **your plan**, **you** will be responsible for all the costs incurred, and if Neuron has made any settlement on **your** behalf, **you** will be responsible for repaying Neuron the amount they have paid.

If you are covered by another insurance plan

If **you** have any other insurance that covers the same costs as **we** do, **we** will only pay **our** proportionate share of the **claim**. In this event, **you** must provide **us** with full details of the other insurance, including the name and address of the other insurer, their policy and **claim** number and any other relevant information, when **you** first submit **your claim**. **We** will then contact the other insurance company to ensure that **we** only pay **our** proportion of the **claim**. This may involve **us** sending **your** personal information regarding **your claim** to the other insurer.

We will also allow sums paid by another insurer to be offset against the **excess** payable under **your plan** with **us**, subject to receiving confirmation from the other insurer of any amounts already paid by them, and subject to the **treatment** costs being eligible for cover under **your plan** with **us**.

Other information about your plan

Plan premiums

Your employer is responsible for paying the **premium**. **We** must be in receipt of the **premium** before **we** will commence **your** cover.

Your plan will only remain in force while **you** are employed by **your employer**. **We** will not pay for any **treatment** expenses incurred after **your** cover has ended, even it was previously authorised.

Unpaid or late premiums

We will automatically cancel **your** cover if **your employer** fails to pay the **premium** on or before the **premium due date**.

We may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **your employer** pays the outstanding **premium** within 30 days of the **premium due date**. During this 30 day period **we** will not accept any **claims** for **treatment** incurred on or after the **premium due date** until **your employer** has paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorised.

If **your employer** does not pay the **premium** within 30 days of the **premium due date**, **we** will cancel the **plan** from midnight on the day before the **premium due date**. Once **we** have cancelled **your plan**, **your employer** will have to reapply for cover and **you** will have to complete a new **application form**, which will be subject to **medical underwriting**.

Changing your cover

Any changes to **your** cover must be requested by **your employer**, and may be subject to further requirements such as requiring **you** to complete a new **application form** which will be subject to **medical underwriting**. **We** cannot accept requests from **you** to change cover for **you** or **your** dependants.

Adding dependants to your plan

If the **plan** includes cover for **employees'** dependants **you** may apply for cover on behalf of **your** spouse.

You may also apply for cover for **your eligible dependant** children, if they are under 18 years old, or under 25 years old if they are in continuous full-time education. **We** reserve the right to request proof of a child being in full-time education.

We will not commence cover for a new **eligible dependant** until **we** have accepted their **application** and **we** have received payment of their **premium** from **your employer**.

Adding newborn babies to your plan

If the **plan** includes cover for **employees'** dependants **you** may add **your** newborn child to **your plan**, without any **medical underwriting**, provided **you** notify **us** of their full name and date of birth, and **your employer** pays the additional **premium** required, within 30 days of their date of birth. If **you** have been insured with **us** for a continuous period of ten months or more at the date of birth, the **date of entry** can be backdated to their date of birth. The child's cover will be restricted to the cover provided

by **your employer's plan type**.

If **you** do not inform **us** about the birth of **your** child within 30 days of their birth, and/or **your employer** does not pay the additional **premium** within 30 days of their date of birth, **you** will have to make a new **application** for **your** child to be added to **your plan**, and this **application** will be subject to **medical underwriting**.

Newborn children who have been born as a result of **assisted reproduction treatment** and born within 36 weeks of conception are always subject to **medical underwriting**.

If **your** newborn child is not added to **your plan** they may still have some cover under **your plan** for their first 90 days of life. Please see the 'Cover for newborn babies' benefit for full details.

In the event of the death of an insured person

If **you** (the **employee**) die and have **eligible dependants** insured under the **plan**, they will no longer be entitled to be insured on the **plan** and will be removed from the date of **your** death. However, they may apply to be insured on their own individual **plan**, provided they are over the age of 18 years.

To enable **us** to do this **we** will require a new **application form** which must be completed and returned to **us** within 30 days of **your** date of death. Provided **we** receive the new **application form**, and provided **premiums** continue to be paid up to date, **we** will continue their cover as before, but subject to **our** individual **premium** rates.

If **your eligible dependants** want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

If **your eligible dependants** are under the age of 18, their legal guardian will have to sign the **application form** on their behalf.

If an insured **eligible dependant** dies, please inform **us** as soon as possible.

Divorce and separation

If **you** have **your** spouse included under **your plan** and **you** become separated or divorced, **we** will have to transfer **your** insured spouse on to their own **plan**. To enable **us** to do this **we** will require **your** spouse to complete a new **application form** which must be completed and returned to **us** within 30 days of **your** date of divorce or separation.

Provided **we** receive the new **application form**, and provided **premiums** are paid by the new **plan holder**, **we** will continue to cover **your** insured ex-spouse as before, but subject to **our** individual **premium** rates. If **your** ex-spouse wants to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

When a child dependant is no longer eligible to be covered under your plan

If one of **your** children has married, or has reached the age of 18

(or the age of 25 if they are in full time education) they will no longer be able to be included on the **plan** from the **renewal date** following their marriage/birthday. However, they may apply to be insured on their own individual **plan**.

To enable **us** to continue their cover as before **we** will require a new **application form** which must be completed and returned to **us** within 30 days of **your renewal date** along with the appropriate **premium** due, which will be subject to **our** individual **premium** rates.

If **your** child wants to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

If **we** do not receive **your** child's **application form** and **premium** within 30 days of **your renewal date**, their cover will automatically cease from midnight on the day before **your renewal date**. If they subsequently wish to apply for cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

Changing your address, country of residence or country of nationality

You must inform **us** if **you** change **your** address and provide **us** with the new details.

If **you** change **your country of residence** or **you** change **your country of nationality**, **you** must tell **us** straight away.

If **your** new **country of residence** is one where it is not suitable to continue **your** cover under **your plan type**, one of **our** insurance partners may be able to offer **you** similar cover under an alternative plan.

If you become a resident in Abu Dhabi

Under the terms of this **agreement**, cover is not available to **you** if **you** become resident in Abu Dhabi. If **you** become resident in Abu Dhabi during **your** annual **period of cover** **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in Abu Dhabi.

If you leave your employment

If **you** leave **your** employment **you** are no longer eligible to be included on **your employer's plan** and **you** will be removed on the date **your** employment ceases. In some circumstances **you** may be allowed to continue cover with **us** on an individual **plan** with no additional **medical underwriting**, but subject to **our** individual **premium** rates. If **you** would like more information about this then please contact **us**.

When we can cancel your plan

We have the right to cancel **your plan** immediately if:

- **your employer** does not pay **your premium** and other charges such as insurance **premium** tax or value added tax within 30 days of any **premium due date**
- **your** employment with the **employer** ceases (and **you** have not submitted an **application form** and paid the required **premium** within 30 days of the date on which it ceased)
- **you** are no longer eligible to be included in the **plan** or **you** move to a country other than the UAE
- **you** have not provided **us** with medical information **we** have requested to enable **us** to assess a **claim** or any potential **claim** that may arise in the future

- **you** have not repaid to **us** fully any ineligible **claim** payments **we** have invoiced **you** with
- **you**, any **insured person** or any person acting on **your** behalf has made any threatening or abusive comment, or used any unacceptable language towards **us** or any member of **our** staff, or any service provider acting on **our** behalf, whether verbally (including any telephone conversation) or in writing (including any electronic communication)
- **we** reasonably suspect that any **insured person** has misled **us** or attempted to mislead **us**, whether intentionally or carelessly, either at the time of joining or when making a **claim**, by:
 - making a **claim** under this policy knowing it to be dishonest, intentionally exaggerated or fraudulent in any way
 - providing **us** with incomplete or false information
 - working with another party to provide false information to **us**
 - changing original documents

If **we** cancel **your plan** for any of the above reasons **we** may also report the matter to the relevant authorities, if appropriate.

When we may apply special terms to your plan

We have the right to apply **special terms** to **your plan** if **you** give **us** inaccurate or incomplete information. Such **special terms** will be applied from **your date of entry**.

Our liability under this plan

Our liability under this **plan** is limited to paying for **treatment** or services in respect of eligible **claims** under this **plan**. The choice of provider of the **treatment** or services for which **you** are claiming under this **plan** is **your** responsibility. **We** make no representations or recommendations regarding the availability and standard of any **treatment** or services offered or provided by any **hospital** or **medical services provider**. **We** will not be held liable to **you** or any **insured person** for any loss, harm or damage of any description resulting from lack of availability or from a defect in the quality of any **treatment** or service offered or provided by any **hospital** or **medical services provider**. This **plan** represents the whole and only **agreement** between **your employer** and the **insurer** relating to the provision of **your** private medical insurance.

Your responsibilities as an employee

It is **your** responsibility to:

- inform **us** if **your** personal details, or the personal details of any **insured person**, change
- keep **us** advised of **your** current email address
- inform **us** if **you** change **your** address, **country of residency** or **country of nationality**

Data protection notice

We think it is important for all **our** customers to be made aware of what information **we** hold about them and to have the reassurance of knowing that **we** comply with the laws of Dubai in respect of the processing of **your** personal data.

We will use **your** information (including information provided about **your eligible dependants**) for the purposes of underwriting and administering **your plan** and processing **claims**. By taking

out a **plan** with **us**, **you** agree to **us** processing **your** personal information and sensitive personal information (e.g. medical records).

We will also use **your** information for statistical data analysis, management information, and fraud prevention purposes. If **you** wish to make a **claim** on **your plan**, this will invariably mean that **you** will have to provide **us** with information regarding **your** medical condition which **we** will then process in order to administer **your claim**.

How to make a complaint

Complaints procedure

Each one of **our** customers is important to **us**. **We** believe that **you** have the right to professional customer service of the highest quality at all times. If you think **we** have fallen short of this standard, please follow the procedures outlined below.

If **you** are not happy with the service **you** have received, **you** may write to **us** at any time at the following address::

Global Plans Team
Dubai Insurance Company
PO Box 3027
Dubai, UAE

Tel +971 4 269 7708

Fax +971 4 269 1304

Email enquiries@globalplans.ae

We will acknowledge receipt of **your** complaint within 2 working days. **We** will investigate **your** complaint and send a response to **you** within 4 weeks of the receipt of your complaint. If **we** are unable to provide **you** with a final response within this time period, **we** will write to **you** advising **you** of when **we** will be able to respond. **We** will endeavour to send a final response to **you** within 8 weeks of the receipt of **your** complaint. If **we** are unable to provide **you** with a final response within this time period, **we** will write to **you** again explaining why and advising **you** of when **you** may expect a final response.

Applicable law

The law of Dubai shall apply to **your plan**.

The Dubai Primary Benefits Plan

The following **table of benefits** sets out the cover provided by the Dubai Primary Benefits **plan**.

Wherever the term 'Full cover' appears in the **table of benefits**, this means full refund of **reasonable and customary** charges, less any **excess** or **co-insurance** shown in the Dubai Primary Benefits **plan table of benefits**.

You may claim under either **your plan** or the Dubai Primary Benefits **plan**, but **you** cannot claim under both **plans** for the same

treatment or medical services. The limits shown in the Dubai Primary Benefits **plan table of benefits** are the maximum amounts **we** will pay after the application of any **excess** and **co-insurance**.

The Dubai Primary Benefits **plan** provides cover for **treatment** that is received at a **hospital** or medical facility within the **Ultra-Restricted network** only. If **you** receive **treatment** at a **hospital** or medical facility that is not part of the **Ultra-Restricted network** **you** cannot claim under the Dubai Primary Benefits.






Key ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Dubai Primary Benefits
Annual benefit limit	
The overall maximum limit that each insured person can claim during any one period of cover .	AED150,000
Cover when you are admitted to hospital	
Important notes:	
<ul style="list-style-type: none"> You must obtain pre-authorisation for all benefits included in this section. 	
Hospital accommodation charges Hospital accommodation charges limited to the cost of a standard single room with an en-suite bath or shower room, when you are an in-patient or day-patient .	○ Full cover
In-patient and day-patient treatment Treatment you receive while you are an in-patient or day-patient , including surgeons', anaesthetists' and doctors' fees, nursing care, drugs and surgical dressings, theatre charges and intensive care, pathology, x-rays, scans, diagnostic tests and physiotherapy.	○ Full cover
Parent accommodation charges The cost of one parent staying in hospital with a child under 16 years of age while the child is receiving eligible treatment covered by their plan .	○ Cover up to AED100 per night
Accommodation of an accompanying person Payable for accommodation of an accompanying person in the same room in cases of critical conditions as recommended by the attending medical doctor/specialist .	○ Cover up to AED100 per night
Road ambulance The cost of a private road ambulance if you need in-patient or day-patient treatment for which you are covered by your plan , and if it is medically necessary for you to travel to the hospital by local road ambulance.	○ Full cover
If you need psychiatric care	
Important notes:	
<ul style="list-style-type: none"> You must obtain pre-authorisation for this benefit. 	
Emergency treatment of a psychiatric condition All treatment must be administered under the direct control of a registered psychiatrist. We do not provide cover under this benefit if the treatment is not required in a medical emergency.	○ Full cover

Key ○ Full cover within annual benefit limit ○ Partial or limited cover ○ No cover ○ Optional cover

Cover	Dubai Primary Benefits
Cover for everyday medical care	
Emergency ward treatment Emergency treatment that you have received at a hospital .	○ Full cover
Out-patient surgical procedures	○ Cover subject to 20% co-insurance
GP and specialist consultations Co-insurance will not apply to follow up visits that occur within 7 days of treatment covered by your plan .	○ Cover subject to 20% co-insurance
Prescribed drugs and dressings	○ Cover up to AED1,500 subject to 30% co-insurance per period of cover
Radiology and diagnostic services Radiology and diagnostic services received as an out-patient in a network hospital . You must obtain pre-authorisation of radiology and diagnostic services except in cases of medical emergency.	○ Cover subject to 20% co-insurance
Physiotherapy Up to 6 sessions undertaken within 3 months of the date of a medical referral letter . If your condition becomes a chronic condition and ongoing physiotherapy is aimed at maintaining, rather than curing it, no further payments will be made.	○ Cover for up to a maximum of 6 sessions , subject to 20% co-insurance , per period of cover
Well-being benefits	
Important notes:	
• You must obtain pre-authorisation for all benefits included in this section.	
For insured persons who are adults Preventive health services as stipulated by the Dubai Health Authority (DHA), for all adults including eligible dependants under your plan .	○ DHA stipulated preventive services only
For insured persons who are children Essential vaccines and inoculations, as stipulated in the Dubai Health Authority Immunization Guidelines, for newborns and children insured as dependants under your plan .	○ DHA stipulated vaccines and inoculations only
If you need treatment for pregnancy & childbirth	
Medical emergency Treatment that is necessary as a result of a medical emergency arising from pregnancy or childbirth, excluding planned caesarean section .	○ Full cover
Routine maternity care and childbirth The following services only are covered under this benefit: Full blood count and platelets, mid-stream urine test and analysis, blood group, Rhesus status and antibodies, VDRL, Rubella serology, HIV, Hepatitis C (for high risk patients only), glucose tolerance (for high risk patients only), full blood sugar, 3 prenatal ultrasound scans, 8 visits to a Primary Healthcare Centre in the Ultra-Restricted network .	○ Cover subject to 10% co-insurance
Natural childbirth	○ Cover up to AED7,000 subject to 10% co-insurance

Key  Full cover within annual benefit limit  Partial or limited cover  No cover  Optional cover

Cover	Dubai Primary Benefits
If you need treatment for pregnancy & childbirth (continued)	
Planned caesarean section	 Cover up to AED10,000 subject to 10% co-insurance
Medically necessary termination of pregnancy	 Cover up to AED10,000 subject to 10% co-insurance
Cover for newborns During your child's first 30 days of life, we will pay for BCG vaccine, hepatitis B and neonatal screening tests (PKU), sickle cell screening, congenital hypothyroidism and congenital adrenal hyperplasia.	 Full cover
If you need emergency dental treatment	
Diagnostic and treatment services required for dental and gum treatment in a medical emergency.	 Cover subject to 20% co-insurance
If you need emergency optical or auditory treatment	
Hearing, vision aids and surgical/laser vision correction required in a medical emergency.	 Cover subject to 20% co-insurance

Definitions

This section explains what **we** mean by certain words and phrases bolded in this **agreement**.

Accident

A sudden, unexpected, unusual, specific, violent, external event which occurs at a single identifiable time and place independently of all other causes, which results directly, immediately and solely in physical bodily injury which results in a loss. In no event shall the contracting of any disease and/or illness (including, but not limited to, heart attack, stroke or cancer), nor the injection or ingestion of any substance, be considered an **accident**. An event which directly or indirectly exacerbates a previously existing physical bodily injury shall not be considered an **accident**.

Acute medical condition

A disease, injury or illness 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.

Advanced imaging

Diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET).

Agreement

This booklet. The **agreement** should be read in conjunction with the **master certificate of insurance** issued to **your employer**, **your** completed and signed **application form** and **your certificate of insurance**.

Application or application form

The **application form** **you** have completed and signed on behalf of **yourself** and on behalf of any **eligible dependants** for whom cover is requested. Please note that on some occasions an alternative form such as a health declaration or an upgrade form may be required to be completed instead of a full **application form**. **We** will advise **you** when this is the case. The alternative form will then be classed as the **application/application form** for the purpose of this **agreement**. Information on previously completed **application forms**, if applicable, may also be used by **us** for underwriting and **claims** assessment reasons.

Area of cover

The territorial limits of **your plan**.

Assistance Service

The emergency assistance company contracted by **us** to provide assistance services to **plan** members at the time of **your claim**. The contact details for the **Assistance Service** can be found at the beginning of this **agreement**.

Assisted reproduction

The use of medical techniques, including, but not limited to, in-

vitro fertilisation (IVF) with or without intra-cytoplasmic sperm injection (ICSI), gamete intrafallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), egg donation and intra-uterine insemination (IUI) with ovulation induction, received during the 3-month period prior to conception.

Certificate of insurance

The confirmation of **your** insurance cover issued by **us**. It confirms the **plan type** **your employer** has chosen, the Neuron network **you** are entitled to use, the **plan** currency, **your area of cover**, **period of cover**, **date of entry**, **renewal date**, **excess** amount, **special terms**, **your country of residence**, **your country of nationality**, and the schedule of **insured persons**. The schedule of **insured persons** lists the persons insured by **us** under **your employer's agreement** with **us**. If there are any changes to the details on **your certificate of insurance** **we** will issue **you** with a new one confirming the changes.

Chronic condition

A disease, illness or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- **you** need to be rehabilitated or specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

Close family member

Your spouse, civil partner, a co-habiting partner, parent, brother, sister, child or grand-child.

Co-insurance

A contribution that **you** must make towards the eligible costs of **your claim**.

Comprehensive network

The **medical services providers** listed as being within Neuron's **Comprehensive network**. For a list of these **medical services providers** go to neuron.ae.

Complications of pregnancy

Treatment received for a medical condition which arises because of the antenatal or post-natal stages of pregnancy.

Congenital condition

Whether hereditary or not, any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not, or any deformity arising during the antenatal stages of pregnancy, or

caused during childbirth.

Country of nationality

Your country of origin, for which **you** hold a passport. If **you** hold more than one passport **your country of nationality** will be the country **you** have declared on **your application form**.

Country of residence

The country in which **you** are habitually resident as specified on **your application form** or subsequently advised to **us** in writing.

Date of entry

The date on which cover for **you**, and each of **your eligible dependants**, first commenced. **Your date of entry** is as stated on **your certificate of insurance**.

Day-patient

A patient admitted to a **hospital** or **day-patient** unit for a medical procedure which for medical reasons could not have been performed on an **out-patient** basis and which requires them to occupy a **hospital** bed for a period of medically supervised recovery, but it is not **medically necessary** for them to occupy a bed overnight.

Dental treatment

Dental procedures undertaken by **your dental practitioner** which are **medically necessary** for the maintenance and/or restoration of oral health, and are provided in accordance with accepted standards of dental practice.

Dentist or dental practitioner

A qualified person legally carrying out this profession in the country in which he or she is located.

Diagnostic tests

Investigations, such as x-rays or blood tests to diagnose the cause of **your** symptoms.

Doctor

See **medical doctor**.

Dubai Health Authority Essential Benefits plan

The minimum benefits required under health insurance **plans** in the Emirate of Dubai, in accordance with the laws of Dubai and circulars and guidelines issued by the Dubai Health Authority. A summary of the Elite Health **plan** equivalent is set out in the **table of benefits** for the Dubai Primary Benefits **plan** on pages 28-30 of this **agreement**.

Eligible dependants

Your spouse and **your** unmarried children (i.e. **your** son, daughter, step-son, step-daughter, adopted children and children subject to legal guardianship) provided the unmarried children are aged less than 18 years old, or less than 25 years old if in continuous full-time education. If a child is adopted or the subject of legal guardianship **we** may require proof. **We** may also require proof of a dependent child being in full time education.

Emergency caesarean section

A caesarean section, which has been scheduled to take place less than 24 hours in advance.

Emergency treatment

Essential **treatment** that is immediately required as a result of a medical emergency that presents a serious threat to the health of the **insured person**, or to the health of an unborn foetus of a mother insured on **your plan**, or (within the first 90 days of life) to the health of a newborn child of a mother insured on **your plan**.

Employee

You, the member of the health **plan** provided by **your employer**.

Employer

The **plan holder** specified as **your** company/**employer** on **your certificate of insurance**.

Excess

The amount stated as the **excess** on **your certificate of insurance** and **your Neuron network card**. **Your excess** will be applied to each consultation that **you** have with a **medical doctor** where a charge is made, and to each visit **you** make to a **dental practitioner**.

General Plus network

The **medical services providers** listed as being within Neuron's **General Plus network**. For a list of these **medical services providers** go to neuron.ae.

Hospital

An establishment which is legally licensed as a medical or surgical **hospital** under the laws of the country in which it is situated.

Innocent bystander

Someone who is not involved with, participating in or reporting on war, acts of foreign enemy 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, or actively participating in operations countering any such activities.

In-patient

A patient who is admitted to **hospital** and who occupies a bed overnight or longer for medical reasons.

Insured person

You and any **eligible dependants** specified in **your certificate of insurance** as being included in the **plan**.

Insurer

The insurance company that provides the insurance cover for **your plan**. The **insurer** is Dubai Insurance Company psc.

Life-threatening condition

A critical medical condition covered by **your plan**, which in the

opinion of the **Assistance Service** constitutes a life-threatening situation which requires immediate **in-patient treatment**.

Master certificate of insurance

The **certificate of insurance** issued to **your employer** which together with this **agreement** and **your certificate of insurance** contains the terms, conditions and exclusions that apply to **you** and **your eligible dependants**.

Medical doctor

A person who is legally qualified in medical practice following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation) to provide medical **treatment** and who is licensed to practise medicine in the country where the **treatment** is received.

Medically necessary

Treatment that is medically appropriate and necessary to treat a condition that is covered under the terms and conditions of this **agreement**, and which is consistent with internationally recognised guidelines. Internationally recognised guidelines means guidelines issued by the Dubai Health Authority, the United Arab Emirates Ministry of Health, the US Federal Drugs Administration, the European Medicines Agency or the UK National Institute for Health and Clinical Excellence (NICE) in the UK.

Medical network provider

A **hospital**, **out-patient clinic**, **medical practitioner** or pharmacy who are part of the Neuron network of medical providers **you** are entitled to use for **treatment** that is covered by **your plan**. The Neuron network of medical providers **you** are entitled to use is as stated on **your certificate of insurance** and on **your Neuron network card**.

Medical practitioner

A person who has full registration under the Medical Acts of the country where they practice and who specialises in nursing, homeopathy, acupuncture, orthopaedic medicine, osteopathy, chiropractic, chiropody, podiatry or physiotherapy **treatment**, and to whom **you** have been referred by a **medical doctor**.

Medical referral letter

A letter from **your medical doctor** or **specialist** which refers **you** to another **medical practitioner** for **treatment** covered by **your plan**. We will only pay for **treatment** when the start date of **your treatment** is within 3 months of the date of **your medical referral letter**.

Medical services provider(s)

A **hospital**, **out-patient clinic**, **medical practitioner**, **dental practitioner** optician or pharmacy.

Medical underwriting

The process of **you** providing and **us** assessing the health and medical information **we** ask for to decide the terms under which **we** will accept **your application** for cover, or for enhanced cover. Based on the information **you** give **us**, **we** may decide to place **special terms** on **your** cover.

Neuron network card

Your personal membership card that will state **your plan type** and the Neuron network **you** are entitled to use. It will also state any **excess** that applies to **your plan**.

Neuron network provider

A medical service provider which is part of the Neuron network of medical service providers **you** are entitled to use for **treatment** that is covered by **your plan**. The Neuron network of medical service providers **you** are entitled to use is as stated on **your certificate of insurance** and on **your Neuron network card**.

Out-of-network penalty

The additional **co-insurance** we will apply to **your claim** settlement amount when **you** have **your treatment** at a **medical services provider** who is not a **Neuron network provider** **you** are entitled to use.

Out-patient

A patient who attends a **hospital** consulting room, emergency room or **out-patient** clinic, when it is not **medically necessary** for them to be admitted as a **day-patient** or an **in-patient**.

Out-patient surgical procedure

An **out-patient** procedure where one or more of the following is **medically necessary**:

- general or local anaesthesia or intravenous sedation
- manipulation or relocation of a fractured bone or dislocated joint by a **medical doctor**
- invasive surgical procedures
- invasive diagnostic procedures involving intra-arterial cannulation
- the use of endoscopic equipment

Period of cover

A period of 12 months from **your date of entry** or from any subsequent **renewal date**. **Your period of cover** is as shown on **your certificate of insurance**.

Plan or plan type

The Elite Silver **plan**, or Elite Gold **plan** or the Dubai Primary Benefits **plan** on which **you** and **your eligible dependants** are covered.

Plan holder

The company or **employer** as stated on **your certificate of insurance**.

Planned caesarean section

A caesarean section which has been scheduled to take place more than 24 hours in advance, whether this be for medical or elective reasons.

Post-hospital treatment

Medically necessary follow-up consultations, physiotherapy, **diagnostic tests** and/or **treatment** required on an **out-patient**

basis following **in-patient** or **day-patient treatment** covered by **your plan** and received within the 90 day period following the date **you** are discharged from **hospital**.

Pre-admission tests

An **out-patient** assessment during which **your** health is assessed in order to confirm that **you** are medically fit to undergo the planned **treatment** and that **you** are sufficiently prepared for it. The assessment may include an electrocardiogram, blood and/or urine tests and a chest x-ray.

Pre-existing medical conditions

Any disease, illness or injury, whether the condition has been diagnosed or not before **your date of entry**, for which:

- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms

Premium

The amount(s) **your employer** is required to pay to **us** annually for **your insurance plan**.

Premium due date

The date on which **your premium** is due to be paid by **your employer**.

Preventive health checks

Health tests, screening and/or clinical procedures specifically designed for disease prevention and early detection.

Preventive health services (DHA)

Preventive services stipulated by the Dubai Health Authority, including initial diabetes screening.

Qualified nurse

A nurse whose name is currently on any official register of nurses maintained by a statutory nursing registration body within the country where **treatment** is provided.

Reasonable and customary

The charge that would typically be made for **your treatment** by **medical services providers** in the country where **you** receive **your treatment**, and for the **medically necessary** length of stay required. If the cost of **your treatment** is not **reasonable and customary**, **we** will only pay up to the amount which is typically charged in that country. If the length of stay is not **reasonable and customary**, **we** will only pay for the **medically necessary** length of stay required. In the event of a dispute, **we** will identify the amount typically charged for **your treatment** by obtaining comparable quotations from three other **medical services providers** in the country where **you** receive **your treatment**, and taking a mean average of these three quotations.

Rehabilitation

Treatment in the form of a combination of therapies such as physical, occupational and speech therapy aimed at restoring full function after an acute event such as a stroke.

Rehabilitation hospital or unit

A medical facility licensed under the regulations of the country in which it operates and designed for patients who no longer need acute **hospital** care but who still require medical or nursing supervision and/or assistance with activities of daily living because of their medical disability.

Related condition

Any disease, illness or injury that is caused by a **pre-existing medical condition** or results from the same underlying cause as a **pre-existing medical condition**.

Renewal date

The **renewal date** of **your employer's plan** as shown on **your certificate of insurance**.

Session

A single continuous consultation during which time **you** may receive advice, **treatment** and/or prescribed medication.

Specialist

A **medical practitioner** who is fully registered by the regulatory body of the country in which he or she practices following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation). They must be on a **specialist** register appropriate for the condition for which **treatment** is sought. Where regulation demands, the **medical practitioner** must also have a licence to practice. **We** reserve the right to withhold or remove recognition of any **specialist** for reasons such as suspension of registration, fraud or unreasonable charges.

Special terms

Any restrictions or **premium** adjustments **we** may apply to **your plan**. Any **special terms** relating to **your plan** will appear on **your certificate of insurance**.

Table of benefits

The table beginning on page 6 which sets out the benefits covered by each **plan type** or the table beginning on page 28 for the Dubai Primary Benefits **plan**.

Terminal medical condition

A condition that has become incurable and all the **treatments** given are to prolong life.

Treatment

Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

Ultra-restricted network

The **medical services providers** listed as being within Neuron's Ultra-Restricted network. For a list of these **medical services providers** go to neuron.ae.

Us, we, our

Dubai Insurance Company psc.

Vegetative state

A state where there is no sign of awareness or any cognitive function, even if the person can open their eyes and/or breathe unaided. If the person is in a **vegetative state** for a continuous period of eight weeks, they will be considered to be in a persistent **vegetative state**.

Waiting period

When specified, the amount of time **you** must be covered by the same **plan** before **you** can **claim** for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**. When a **waiting period** is not specified there is no **waiting period** applicable.

You, your, yourself

Any and all persons named in the schedule of **insured persons** on **your certificate of insurance**.

We're here to help

Call us on +971 4 269 7708
or visit globalplans.ae

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