Plans designed by
William
Russell

Flex Health Plan Agreement

Employees & Families

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DUBAI INSURANCE

For members with a Flex health plan whose period of cover starts on or after **01 June 2020**

Introducing your health plan	3
Your plan agreement	4
Your area of cover	5
What you're covered for	6
What you're not covered for	14
If you need to make a claim	17
Other information about your plan	20
How to make a complaint	23
The Primary Benefits plan	24
Definitions	27

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 Certificate of Insurance** and the **application form you** originally submitted to **us**. Along with **your employer's master Certificate of Insurance**, these documents form the contract between **your employer**, **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**

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

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

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.

William Russell

William Russell Ltd is the designer of **your plan** and the inspiration behind the benefits and member experience **we** provide to **you**. William Russell Ltd is authorised and regulated by the UK Financial Conduct Authority under reference number 309314.

NextCare

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

Contact details

If you have an enquiry about your plan or insurance	**Phone** +971 4 269 7708 **Fax** +971 4 269 1304 **Email** enquiries@globalplans.ae
If you need to make a claim	**Phone** +971 4 270 8800 **Fax** +971 4 270 8329 **Email** nextcare@nextcarehealth.com **Web** nextcarehealth.com
If you need to contact our 24-hour emergency medical Assistance Service	**For emergency medical assistance please call the following number: -** +44 1243 621 155 **For non-emergencies, please contact us by email: -** william.russell@cegagroup.com
If you'd like to write to us	**Global Plans Team** Dubai Insurance Company psc PO Box 3027 Dubai, UAE
If you'd like to write to NextCare	**NextCare Claims Management LLC** PO Box 80864 Dubai, UAE

Your plan agreement

This **agreement**, together with the **application form you** originally submitted to **us**, **your Certificate of Insurance**, and **your employer's master Certificate of Insurance**, make up the contract between **you**, **your employer**, and **us**.

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 **your employer's 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 refuse to offer cover, or only offer cover subject to **special terms**.

The purpose of your plan

Your plan provides **you** with benefit for the cost of treating eligible medical conditions which arise after **your date of entry**.

We will pay for the **reasonable and customary** costs of **medically necessary treatment** of 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.

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**.

Your obligation to provide information relating to you and your dependants' medical history

We rely on the information **you** supply to **us** in **your application form** when **we** decide whether or not to accept **your application**, and 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 eligible **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**.

Eligible medical services providers

The NextCare network of **medical services providers you** are entitled to use is as stated on **your Certificate of Insurance**, **your network card**, or **smartphone application**.

If **your** cover is restricted to the benefits of the **Primary Benefits plan you** will only be entitled to use a **medical services provider** within **Restricted Network 3**. If **you** use a **medical services provider** that is not in **Restricted Network 3 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 **areas of cover,** and their corresponding territorial limits, are stated below.

Local

Your cover is restricted to **treatment** that **you** receive within the United Arab Emirates or within **your country of nationality**, if that country is India, Pakistan, Sri Lanka, Bangladesh, Nepal, Bhutan or the Philippines.

Regional

Your cover is restricted to **treatment** received in the United Arab Emirates and most countries in the Middle East (excludes Iran, Syria and Yemen), Africa, Indian Subcontinent, Southeast Asia, and Latin America.

The starting point for this **area of cover** is worldwide, but subject to the following restrictions and exclusions: -

No cover is provided within the United States of America, Canada, any **Caribbean country or island**, or the **London area**.

Within the European Union, United Kingdom, Andorra, Channel Islands, Gibraltar, Greenland, Iceland, Liechtenstein, Monaco, Norway, San Marino, Switzerland, Australia, China, Hong Kong, Japan, Macau, New Zealand, Singapore and Taiwan, **your** cover is limited to: -

- essential **emergency treatment** covered by **your plan** that **you** receive while on a **temporary trip** (excludes medical evacuations, **pre-existing medical conditions** and **related conditions** or conditions that could reasonably have been delayed until **your** return to a country within **your area of cover**); and
- 90 days per **temporary trip**; and
- a maximum benefit of US$50,000 per **period of cover**.

We will not pay for **treatment** if you have travelled to a restricted country or region knowing that **you** would require **treatment**.

Worldwide

This **area of cover** is only available if **you** have the **General Network** or the **General Network Plus**. With the worldwide **area of cover**, **you** can seek **treatment** anywhere in the world subject to the following restrictions: -

No cover is provided for emergency medical evacuations to, within or from, the United States of America or the **London area**.

Within the United States of America and the **London area, your** cover is limited to: -

- essential **emergency treatment** covered by **your plan** that **you** receive while on a **temporary trip**; and
- 90 days per **temporary trip**; and
- a maximum benefit of US$50,000 per **period of cover**.

Within Switzerland, Singapore, Hong Kong, Japan, and Macau **your** cover is limited to: -

- up to 80% of eligible, elective **treatment** costs; and
- up to 100% of any essential **emergency treatment** costs; and
- 90 days per **temporary trip** (cover is limited to 80% of costs for **temporary trips** over 90 days); and
- a maximum benefit of US$100,000 per **period of cover**.

We will not pay for **treatment** if **you** have travelled to a restricted country or region knowing that **you** would require **treatment.**

Restricted Network 3

Cover is restricted to the **medical services providers** within **Restricted Network 3**, all of which are located within the United Arab Emirates.

What you're covered for

The following **table of benefits** sets out the cover provided by **your** Flex **plan**. The configuration of the Flex **plan 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 a 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-authorisation. If **you** do not obtain pre-authorisation for these benefits, **we** will only pay 80% of the **reasonable and customary** cost of **treatment**.

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

If cover in respect of any benefit of the Flex **plan** is lower than the benefit provided under the **DHA** Essential Benefits plan, the cover provided under the **DHA** Essential Benefits plan shall apply.

If **you** receive **your treatment** at a **medical services provider** which is not within the NextCare network stated on **your Certificate of Insurance**, **network card** or **smartphone application**, penalties will apply. Please refer to the *If you need to make a claim* section of this **agreement** for further information.

If **your plan** is the **Primary Benefits plan**, which provides cover for **medically necessary treatment** at **medical services providers** within **Restricted Network 3**, please refer to the table of benefits on pages 24-26 of this **agreement**.

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

	Flex Core
Annual benefit limit The overall maximum limit that each **insured person** can **claim** during any one **period of cover**. **Your** annual benefit limit is selected by **your employer** and is stated on **your Certificate of Insurance**.	(Optional) **Flex 1** US$150,000 or AED550,500 (when selected by **your employer**) (Optional) **Flex 2** US$250,000 or AED917,500 (when selected by **your employer**) (Optional) **Flex 3** US$500,000 or AED1,835,000 (when selected by **your employer**)
Hospital costs Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.	
Hospital accommodation The cost of a standard, private single room with an en-suite bath or shower room, when **you** are an **in-patient** or **day-patient**.	(Full) Private hospital room
Hospital treatment **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. **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**. **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.	(Full) Full cover

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

	Flex Core
Hospital costs (continued) Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.	
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**.	Full cover
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**.	Up to US$27 or AED100 per night
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.	Full cover
Cancer treatment Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.	
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.	Full cover
Cancer genome tests The cost of tests to sequence the genes of cancer cells.	Up to US$6,000 or AED22,020 per **period of cover**
Organ, bone marrow or tissue transplants Important notes: - • **You** must obtain pre-authorisation for all benefits 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.	
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.	Full cover
Donor costs Medical costs associated with the donor as an **in-patient** or **day-patient**.	Up to US$25,000 or AED91,750 per transplant
Kidney dialysis Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.	
Short-term kidney dialysis of up to 4 weeks, if **you** need this immediately before or after a kidney transplant operation covered by **your plan**. **We** will also pay for dialysis for up to 4 weeks if this is needed temporarily for sudden kidney failure resulting from a disease or injury, covered by **your plan**, which affects another part of **your** body. **We** do not cover regular or long-term kidney dialysis.	Full cover

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

	Flex Core
Reconstructive surgery Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.	
A maximum of two surgeries per lifetime 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.	Full cover
Mental health treatment Important notes: - • **You** must obtain pre-authorisation for all benefits 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 phobias, hypnotherapy, postnatal depression or marriage counselling, or psycho-geriatric conditions including Alzheimer's disease or dementia.	
Annual limit for mental health treatment The overall maximum limit to the amount that **you** can **claim** for all benefits in the *mental health treatment* section during any one **period of cover**.	US$1,362 or AED5,000 per **period of cover**, subject to a 30% **co-insurance**
In-patient and day-patient mental health treatment **In-patient** and **day-patient treatment** received in a recognised mental health unit of a **hospital**.	Up to the annual limit for **mental health treatment**
Out-patient mental health treatment **Specialist** mental health consultations with a registered psychiatrist or psychologist when **you** have been referred by a **medical doctor**.	Up to the annual limit for **mental health treatment**
Medical appliances	
Medical aids Supplying, fitting or hiring instruments, apparatuses or devices which are medically prescribed as a medical aid to **you** (*eg* crutches, wheelchairs, orthopaedic supports/braces, orthotics, stoma supplies, compression stockings) when it immediately follows **in-patient**, **day-patient** 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.	Up to US$250 or AED918 per medical condition per **period of cover**
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.	Full cover

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

	Flex Core
Out-patient treatment Important notes: - • The **co-insurance** will not apply to **out-patient** follow-up visits that occur within 7 days of **treatment** covered by **your plan**. • **You** must obtain pre-authorisation for certain benefits in this section.	
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**. **We** do not cover home visits.	Cover is subject to the **co-insurance** chosen by **your employer**
Emergency ward treatment **Emergency treatment** that **you** have received at a **hospital**.	Cover is subject to the **co-insurance** chosen by **your employer**
Out-patient surgical procedures Surgical procedures where it is not **medically necessary** for **you** to be admitted to **hospital** as an **in-patient** or **day-patient**.	Cover is subject to the **co-insurance** chosen by **your employer**
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**. **You** must obtain pre-authorisation for all advanced **diagnostic tests**.	Cover is subject to the **co-insurance** chosen by **your employer**
Complementary 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**. Medication provided by complementary therapists is not covered under this benefit.	Up to 10 **sessions** per **period of cover** for **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**
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**. After **your** first 6 **sessions** of physiotherapy, if **you** need more **sessions you** must contact **us** for pre-authorisation. **We** will write to **your doctor** for a medical report in order to assess **your claim** further. After **your** first 6 **sessions**, **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 rather than curing it, no further payments will be made.	Cover is subject to the **co-insurance** chosen by **your employer**

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

	Flex Core	Flex Up
Well-being benefits		
DHA-mandated preventive health and well-being • Preventive screening for diabetes every three years for **insured persons** aged 30 and over, or every year for **insured persons** aged 18 and over who are considered high risk—as stipulated by the **DHA**. • Hepatitis C screening and **treatment** (to be followed as per the guidelines set out in the **DHA** Hepatitis C Support Programme) • Cancer screening and **treatment** (to be followed as per the guidelines set out in the **DHA** Cancer Support Programme) • Adult pneumococcal conjugate vaccine (as per guidelines set out by **DHA** for the adult pneumococcal vaccination)	Full cover	Full cover
Additional preventive health and well-being **Preventive health checks** and tests for adults, including: - • health screens (*eg* tests for cholesterol, high blood pressure, anaemia, lung/kidney/liver function, cardiac risk) • Papanicolaou (PAP) test • mammogram • flu jabs • **medically necessary** vaccinations • hearing test • eye examination	No cover	**Option A** Up to US$250 or AED918 per **period of cover** (only if selected by **your employer**) **Option B** Up to US$500 or AED1,835 per **period of cover** (only if selected by **your employer**)
Well-child benefit Developmental check-ups for children up to six years old.	Full cover	Full cover
Child vaccinations Essential vaccinations and inoculations for children up to six years old, as stipulated by the **DHA**.	Full cover	Full cover
Pre-existing and chronic conditions		
Treatment for **chronic conditions** and **pre-existing medical conditions**.	Up to US$40,872 or AED150,000	Up to US$40,872 or AED150,000
Rehabilitation treatment Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.		
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**. 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**.	Up to 7 days per medical condition	Up to 7 days per medical condition
Home nursing costs Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.		
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**	Up to 2 weeks per medical condition	Up to 2 weeks per medical condition

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

	Flex Core	Flex Up
Lifetime care Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.		
Lifetime limit for all lifetime care The overall maximum limit to the amount that **you** can **claim** for all benefits in the *lifetime care* section that are covered by **your plan** during **your** lifetime.	US$40,872 or AED150,000	US$40,872 or AED150,000
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**.	Up to the lifetime limit for all lifetime care	Up to the lifetime limit for all lifetime care
Artificial life maintenance **Treatment you** require after **you** have already been on **artificial life maintenance** for 8 weeks.	Up to the lifetime limit for all lifetime care	Up to the lifetime limit for all lifetime care
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**.	Up to the lifetime limit for all lifetime care	Up to the lifetime limit for all lifetime care
Optical and auditory care Important notes: - • **You** are eligible for the Flex Up benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.		
Emergency optical or auditory care Hearing, vision aids, and surgical/laser vision correction required in a medical emergency.	Cover is subject to the **co-insurance** chosen by **your employer**	Cover is subject to the **co-insurance** chosen by **your employer**
Optical care **We** will pay for an annual optical test. Within this benefit, **we** will pay for lenses, frames, and contact lenses only upon a change of prescription. **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). The optical care benefit is limited to US$100 or AED367 for adults and for children, or to US$200 or AED734 for adults and for children, depending on which option **your employer** has selected. **You** are not eligible for cover if neither option is selected.	No cover	**Option A** Up to US$100 or AED367 for adults and children per **period of cover** (only if selected by **your employer**) **Option B** Up to US$200 or AED734 for adults and children per **period of cover** (only if selected by **your employer**)

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

	Flex Core	Flex Up
Pharmacy costs Important notes: - • **You** are eligible for the Flex Up benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance.** • The benefits in the section are subject to the **co-insurance** stated on **your network card** and **Certificate of Insurance**.		
Pharmacy costs for all conditions covered by **your plan**.	(Partial or limited cover) Up to US$5,000 or AED18,350 per **period of cover**, subject to the **co-insurance** stated on your **network card** and **Certificate of Insurance**	(Optional cover) Up to US$10,000 or AED36,700 per **period of cover**, subject to the **co-insurance** stated on your **network card** and **Certificate of Insurance** (only if selected by **your employer**)
Dental costs Important notes: - • **You** are eligible for the Flex Up benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance.** • 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.		
Emergency dental treatment Diagnostic and **treatment** services required for dental and gum **treatment** in a medical emergency.	(Partial or limited cover) Cover is subject to the **co-insurance** chosen by **your employer**	(Partial or limited cover) Cover is subject to the **co-insurance** chosen by **your employer**
Dental Basic **We** will pay for the following basic dental costs: - • screening (*eg* the checking for and/or the assessment of any diseased, missing and filled teeth including X-rays where necessary) twice per year • scaling and polishing and sealing (twice per year) • fillings (both composite and amalgam) • simple extractions • root canal **treatment** The Dental Basic benefit is limited to US$250 or AED918, or US$500 or AED1,835, per **period of cover**. **You** are not eligible for cover if neither option is selected by **your employer**.	(No cover) No cover	(Optional cover) **Option A** Up to US$250 or AED918 per **period of cover**, subject to a nil or 20% **co-insurance** (as selected by **your employer**) ——— (Optional cover) **Option B** Up to US$500 or AED1,835 per **period of cover**, subject to a nil or 20% **co-insurance** (as selected by **your employer**)
Dental Plus **We** will pay for the following advanced dental costs: - • denture repair • full/partial dentures • dental bridges • crowns, inlays, and onlays • dental implants	(No cover) No cover	(Optional cover) Up to US$1,000 or AED3,670 per **period of cover**, subject to a 20% **co-insurance** (only if selected by **your employer**)

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

	Flex Core	Flex Up
Maternity costs Important notes: - • **You** are eligible for the Flex Up benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance.** • Dependent children included in **your plan** are not eligible for these benefits. • **You** must obtain pre-authorisation for all benefits in this section. • **We** do not cover the **treatment** of any newborn child born following **assisted reproduction** (*eg* 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 **in-patient** maternity care and newborn care benefits. • **We** do not cover pregnancy test kits 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. • **We** do not cover breast pumps.		
Out-patient maternity care and newborn care **We** will pay for the following out-patient routine maternity costs: - • pre-natal tests and examinations, as per **DHA** policies • post-natal **treatments** and examinations, as per **DHA** policies • supplements and vitamins as recommended by a **medical doctor**	Full cover	Full cover
Routine in-patient maternity care and newborn care **We** will pay for the following routine maternity costs: - • natural childbirth • childbirth by **planned caesarean section** • any **hospital** accommodation costs for the newborn baby • basic newborn healthcare (physical examination, vitamin K, hepatitis B vaccine, BCG vaccine, one hearing test, blood tests for PKU, congenital hypothyroidism and G6PD, prior to discharge from the **hospital**) • home birth, where a midwife is present The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. Any **hospital** or birthing centre accommodation costs will be limited to the cost of a standard **hospital** room.	Up to US$2,725 or AED10,000 per pregnancy	**Option A** Up to US$5,000 or AED18,350 per pregnancy (only if selected by **your employer**) **Option B** Up to US$7,000 or AED25,690 per pregnancy (only if selected by **your employer**)
Complications of pregnancy and childbirth Emergency **in-patient** or **day-patient treatment** necessary as a direct result of a **complication of pregnancy** or childbirth that threatens the life of the mother. Childbirth by emergency caesarean section, including surgeons', anaesthetists', and theatre fees, and any additional accommodation charges incurred as the result of the surgical procedure, are also covered under this benefit. **We** do not provide cover under this benefit for complications arising from a pregnancy established through **assisted reproduction** (*eg* IVF) until after the standard 12-week scan, irrespective of how long **you** have been covered by **your plan.**	Up to US$40,882 or AED150,000 per pregnancy	Up to US$40,882 or AED150,000 per pregnancy
Treatment for newborn babies **We** will pay the following costs for treatment that **your** newborn baby receives during their first 30 days of life: - • **DHA**-mandated **treatment your** newborn baby receives as an **out-patient** (including consultations, tests, procedures, vaccinations, and medication). **We** will pay the following costs for treatment that **your** newborn baby receives during their first 90 days of life: - • Emergency **treatment your** newborn baby receives as an **in-patient** or **day-patient** (including **treatment** of birth defects and congenital or hereditary conditions) for any medical conditions they develop during their first 90 days of life. • Accommodation costs for one parent to stay with the newborn baby if the baby is hospitalised. • Any hospital accommodation costs for the newborn baby. The limits shown apply to each pregnancy, regardless of the number of children born.	Up to US$40,882 or AED150,000 per pregnancy	Up to US$40,882 or AED150,000 per pregnancy

What you're 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**.

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
- VAT and tax charges

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 caused directly or indirectly as a result of any such abuse or addiction
- any illness or injury caused 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**. Patch testing 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 in the *lifetime care* section of the **table of benefits**.

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 investigations or **treatment** related to 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**.

Consultations or investigations when you are not present

You are not covered for consultations or investigations where **you** are not present, without prior agreement from **us**. This includes, for example, interviews by medical practitioners with other medical practitioners or with family members.

Convalescence, rehabilitation, nursing homes, and health spas or 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.

Drugs prescribed for out-patient mental health treatment

You are not covered for drugs prescribed for **out-patient** mental health **treatment**.

Experimental drugs and treatments

You are not covered for **treatment** or medicine which in **our** reasonable opinion is experimental or unproven based on generally accepted current clinical evidence and generally accepted medical practice.

Eyesight

You are not covered for: -

- **treatment** to correct **your** eyesight, such as laser **treatment**, refractive keratotomy and photorefractive keratotomy
- upgraded lenses as part of an eye operation, such as cataract surgery
- spectacles, and other visual aids, **treatment** of strabismus (squint) or amblyopia (lazy eye)
- sight tests (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**)

Failure to follow medical advice

You are not covered for: -

- **treatment** arising from or related to **your** unreasonable failure to seek or follow medical advice and/or prescribed **treatment**, or **your** unreasonable delay in seeking or following such medical advice and/or prescribed **treatment**
- complications arising from ignoring such advice

Foetal surgery

You are not covered for surgery undertaken on a child while it is in its mother's womb.

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 in the *cancer treatment* 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** (unless covered under **your plan** under the emergency treatment for newborn babies benefit in the *maternity costs* section of the **table of benefits**)
- hearing aids
- hearing tests (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**)

Infertility, IVF, and assisted reproduction

You are not covered for: -

- testing or diagnosis related to infertility
- infertility **treatment**, **assisted reproduction** (*eg* 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.

Natural changes as a result of ageing

You are not covered for: -

- **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing *eg* menopause or puberty
- bone densitometry
- reproductive hormone testing, reproductive hormone therapy or hormone replacement therapy

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* section of the **table of benefits**.

Preventive surgery

You are not covered for surgery when no physical signs or symptoms are shown, or no diagnosis has been made.

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 in (including training for or practising for) any kind of professional sport or professional racing (by professional, **we** mean sport where **you** are being paid to participate and/or **you** are receiving sponsorship or other benefits as a result of **your** participation)
- participation in (including training for or practising for) 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

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.

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, 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, other than any **treatment** available to **you** under the routine maternity care and childbirth benefit in the *maternity costs* 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 siege or attempted overthrow of a government, in a country or region that the British Foreign & Commonwealth Office has advised its citizens to leave, or advised its citizens against all travel to, unless **you** are an **innocent bystander**.

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

As stated in the **table of benefits**, there are certain benefits and **treatments** for which **you** must obtain pre-authorisation.

If **you** need to claim for a benefit or **treatment** for which **you** must obtain pre-authorisation, **you** must contact NextCare or the **Assistance Service** in advance of starting **your treatment** and give them all the information they require to assess if **your** proposed **treatment** will be eligible for cover under **your plan**. If **your** proposed **treatment** is eligible for cover, NextCare or the **Assistance Service** will pre-authorise all eligible expenses. **We** will not pay for any **treatment** costs or expenses that have not been pre-authorised by NextCare or the **Assistance Service** in advance.

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

1. Contact NextCare

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 NextCare, who can advise **you** whether the proposed **treatment** will be covered by **your plan**. The contact details for NextCare can be found at 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 NextCare network **you** are entitled to use is as stated on **your Certificate of Insurance**, **network card** or **smartphone application**. To check that the **hospital**, **out-patient** clinic or **pharmacy** that **you** want to use is part of the NextCare network stated on **your** card, please go to nextcarehealth.com.

If the provider **you** intend to use is within the NextCare network stated on **your network card**, please go to **Step 3.1** below

If the provider **you plan** to use is not within the NextCare network stated on **your 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 NextCare network you are entitled to use

When **you** attend **your** appointment, please present **your network card** or Emirates ID card (which also contains **your** NextCare details) to the **medical services provider**. The **medical services provider** will ask **you** to show an official form of photographic ID, which **you** must provide before **treatment** can take place.

Certain procedures and tests require authorisation by NextCare before the clinic or **hospital** can proceed with them. All **medical services providers** within the NextCare network are aware of these requirements and will contact NextCare 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 services provider** in respect of each **doctor's** consultation, or each visit to a **dentist**.

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

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

Our right to withdraw the NextCare service at any time

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

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

Customers with a Flex 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** receive 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 network**, and 25% if **you** have the **General Plus network**.

Customers with a Primary Benefits plan

There is no cover for **treatment you** receive outside the **Restricted Network 3. You** will only be reimbursed for eligible **treatment you** receive within the **Restricted Network 3**.

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 either by NextCare if **you** are in the UAE, or by the **Assistance Service** if **you** are travelling outside the UAE.

Please contact NextCare or the **Assistance Service** as soon as **you** know that **you** need **in-patient** or **day-patient treatment**. **You** must let them know that **you** need **in-patient** or **day-patient treatment** at least 48 hours in advance of **your admission**. This gives them sufficient time to contact the **hospital** to obtain the necessary medical information.

When **you** contact NextCare or the **Assistance Service**, they will ask **you** to complete a pre-authorisation form and a consent form that permits the **hospital** to release the necessary medical information to them. Once NextCare or the **Assistance Service** has received all the medical information that they require, both from the **hospital** and **yourself** (including any other information **we** might need), they will advise **you** if the proposed medical **treatment** will be covered by **your plan**.

If **you** contact NextCare or the **Assistance Service** less than 48 hours in advance of **your** admission, they may be unable to pre-authorise **your treatment** in time. This means **you** may have to pay for the **treatment yourself** and submit a **claim** for reimbursement to NextCare or the **Assistance Service** later. In some instances, they may decline **your** reimbursement **claim** or they may subject **your** reimbursement **claim** to a 20% **co-insurance**.

If **you** are admitted to **hospital** in an emergency and it is not reasonably possible for **you** to contact NextCare or the **Assistance Service** in advance of **your** admission, they will consider **your claim** provided **you** contact them within 24 hours of **your** admission. If **you** do not contact them within 24 hours, they may decline **your claim** or subject it to a 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 NextCare 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

The best way to submit **your claim** for eligible **treatment** costs is through the NextCare smartphone application or the myNextCare portal.

Alternatively **you** can download a claim form from NextCare's website.

Please complete Section A of the claim form and sign the Patient's Consent and Declaration sections 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@nextcarehealth.com.

NextCare 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: -

- If **you** are claiming for the well-being benefit, please send NextCare the fully itemised invoices for which **you** are claiming reimbursement, together with **your** bank account details.
- If **you** are claiming for the compassionate home visit benefit please send NextCare 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 NextCare **your medical referral letter**. If **you** are claiming for a PET scan, **you** must also send NextCare **your specialist's medical referral letter**.

Supplying the information required to process your claim

NextCare can accept the information required to process **your claim** via the NextCare smartphone application or the myNextCare portal.

Alternatively, scan **your** itemised invoices, receipts, **medical referral letter** (when required), and **your** fully completed claim form and email them all to reimbursement.claims@nextcarehealth.com. Please always retain the original copies of everything for a period of 12 months as NextCare reserve the right to receive these documents before they assess **your claim**. NextCare 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. NextCare will not pay any invoices they receive more than 12 months after **your treatment** date.

NextCare 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 United States of America must be pre-authorised in advance by **us** or by the **Assistance Service**. **We** will not pay for any **treatment** in the United States of America that has not been pre-authorised.

If **we** instruct a local agent to arrange the billing or cost adjustment of **your** medical **treatment** expenses in the United States of America, 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

NextCare 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**.

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

Exchange rates

NextCare 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**, **network card** or smartphone application is the amount each **insured person** will have to pay towards the cost of their **treatment**. The **excess** is taken per medical condition, per **period of cover**.

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 Certificate of Insurance**, **network card** or smartphone application.

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

If **you** have a **plan** which has an **excess** per **claim**, this is the amount **you** will have to pay each time **you** make a new **claim** for **treatment** of a condition that is covered by **your plan.** If **you** subsequently suffer a new occurrence of that condition, this will be treated as a new **claim**, and **we** will apply the **excess** again to that new **claim**. If your course of **treatment** spans two **periods of cover**, **we** will apply the **excess** again when **your plan** renews.

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

NextCare 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, NextCare will not be able to assess **your claim**.

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

If NextCare 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 NextCare has made any settlement on **your** behalf, **you** will be responsible for repaying NextCare 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 **you** only receive a proportion of **your claim** for damages then **you** must repay to **us** the same proportion of **our** costs.

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.

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 **your 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 **your plan** from midnight on the day before **your 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** must apply for cover on behalf of **your** spouse.

You must also apply for cover for **your eligible** dependent 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 twelve 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**.

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**.

In the event of the death of an insured person

If **you** (the **employee**) die and have **eligible dependants** insured under **your 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 the required **premium**, **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 anyway 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** as they will no longer be entitled to be covered on **your employer's 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 the 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, irrespective of **your** nationality. 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 Switzerland is or becomes your country of residence

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

If the USA is or becomes your country of residence

Under the terms of this **agreement** cover is not available to **you** if the United States of America is or becomes **your country of residence**, irrespective of **your** nationality. If the United States of America 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 United States of America.

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 a personal health **plan** with no additional **medical underwriting**, but subject to **our premium** rates for personal health **plans**. If **you** would like more information about this then please contact **us**.

Cancelling your plan

If **you** wish to cancel **your plan**, or if **you** want to cancel cover for one of **your dependants**, **you** must instruct **us** in writing by letter, email or fax. **We** will cancel cover from the date we receive **your** written instructions, or from a date in the future that **you** have specified. **We** will not cancel cover from a date prior to **us** receiving **your** written instruction to cancel.

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 VAT 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** 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.

We have the right to cancel **your** plan from **your renewal date** if you move to a country where **we** are unable to offer continued cover due to compliance and/or legal reasons.

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 **you** and the **insurer** relating to the provision of private medical insurance.

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 administrating **your plan** and processing **claims**. By taking out a **plan** with **us**, **you** agree to **us** processing **your** personal information and sensitive personal information (*eg* 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

Each one of **our** members 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

Phone +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 Primary Benefits plan

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

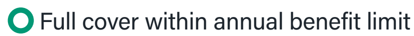
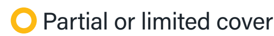
You may claim under either **your plan** or the **Primary Benefits plan**, but **you** cannot claim under both **plans** for the same **treatment** or medical services.

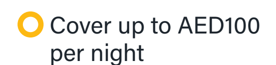
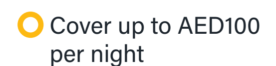
The limits shown in the **table of benefits** are the maximum amounts **we** will pay after the application of any **excess** and **co-insurance**, and will be subject to the annual benefit limit and any other specified applicable benefit limits.

Wherever the term *Full cover* appears in the **table of benefits**, this means a 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.

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

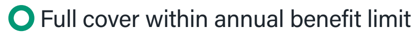
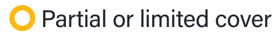
The **Primary Benefits plan** provides cover for **treatment** you receive at a **medical services provider** within the **Restricted Network 3** only. If **you** receive **treatment** at a **medical services provider** that is not part of the **Restricted Network 3**, **you** cannot make a claim under this **table of benefits**.

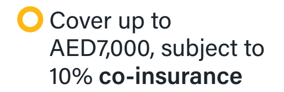
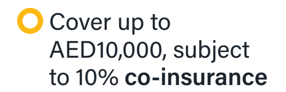
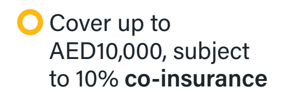
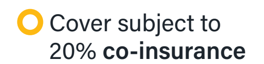
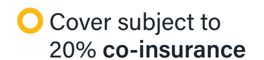
Key  Full cover within annual benefit limit  Partial or limited cover

	Primary Benefits plan
Annual benefit limit The overall maximum limit that each **insured person** can **claim** during any one **period of cover**.	AED150,000
Hospital costs Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.	
Hospital accommodation charges The cost of a standard, private single room with an en-suite bath or shower room, when **you** are an **in-patient** or **day-patient**.	Full cover
In-patient & 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
Mental health treatment Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.	
Emergency treatment of a mental health 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

	Primary Benefits plan
Cover for everyday medical care	
Emergency ward treatment **Emergency treatment** that **you** receive 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 up to 6 **sessions**, subject to 20% **co-insurance** per **period of cover**
Well-being benefits Important notes: - • **You** must obtain pre-authorisation for all benefits in this section.	
For insured persons who are adults **Preventive health services** as stipulated by the **DHA**, for all adults including **eligible dependants** under **your plan**.	**Preventive health services** stipulated by the **DHA** only
For insured persons who are children Essential vaccines and inoculations as stipulated in the **DHA** Immunization Guidelines for newborn babies and children who are insured as dependants under **your plan**.	Essential vaccines and inoculations stipulated by the **DHA** only
If you need treatment for pregnancy and 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 Only the following services 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 **Restricted Network 3 network**. • Pre-natal tests and examinations, as per **DHA** policies • Post-natal **treatments** and examinations, as per **DHA** policies	Cover subject to 10% **co-insurance**

Key  

	Primary Benefits plan
If you need treatment for pregnancy and childbirth (continued)	
Emergency ward treatment	 Cover up to AED7,000, subject to 10% **co-insurance**
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 newborn babies 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 emboldened 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 diagnostics

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

Agreement

The contents of this document, read in conjunction with **your** completed and signed **application form**, **your Certificate of Insurance**, and **your employer's master 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** or **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**.

Artificial life maintenance

When **you** require medical equipment that assists or replaces important bodily functions, including mechanical ventilation, percutaneous endoscopic gastronomy (PEG), and nasal feeding.

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 intracytoplasmic sperm injection (ICSI), gamete intra-fallopian 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.

Caribbean country or island

All countries in the Caribbean region including the West Indies and all islands surrounded by or bordering the Caribbean Sea.

Certificate of Insurance

The confirmation of **your** insurance cover issued by **us**. It confirms the **plan your employer** has chosen, the NextCare network **you** are entitled to use, **your 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

Claim

A course of **treatment** for a specific illness, injury, medical condition, dental condition or pregnancy.

Close family member

Your spouse, parent, brother, sister, child or grandchild.

Co-insurance

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

Complications of pregnancy

Treatment received for a medical condition which arises because of the antenatal or postnatal 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** 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 clinically 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.

DHA

Acronym for the Dubai Health Authority.

Diagnostic tests

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

Doctor

See **medical doctor**.

Eligible dependants

Your spouse and **your** unmarried children (*ie* **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 must take place immediately and cannot be planned.

Emergency treatment

Essential **treatment** that is immediately required as a result of 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, a member of the business health **plan** purchased by **your employer**.

Employer

The **plan holder** specified as **your** company or **employer** on **your Certificate of Insurance**.

Excess

The amount stated as the **excess** in **your Certificate of Insurance** or **network card**. **Your excess** will be applied to each consultation **you** have with a **medical doctor**, each pre-natal check, each therapy session (physical or mental) where a charge is made, and each visit **you** make to a **dental practitioner**. If a follow up consultation is required within 7 days of the initial **treatment**, a further **excess** will not be applicable.

General network

The **medical services providers** listed as being within NextCare's **General network**. For a list of these **medical services providers** go to nextcarehealth.com.

General Plus network

The **medical services providers** listed as being within NextCare's **General Plus network**. For a list of these **medical services providers** go to nextcarehealth.com.

Hospital

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

Indian Subcontinent

India, Pakistan, Sri Lanka, Bangladesh, Nepal or Bhutan.

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.

London area
Any address in the United Kingdom within the E, EC, N, NW, SE, SW, W or WC postcode areas.

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 necessary** and appropriate. The **treatment** must be: -

- essential to diagnose or treat a patient's condition, illness or injury;
- consistent with the patient's symptoms, diagnosis or **treatment** of the underlying condition;
- in accordance with generally accepted medical practice and professional standards of medical care at the time;
- required for reasons other than the comfort or convenience of the patient or his or her physician
- proven and been demonstrated to have medical value, with international medical and scientific evidence of the effectiveness and safety of the **treatment**;
- considered to be the most appropriate type and level of **treatment** taking patient safety and cost effectiveness into consideration;
- provided at an appropriate facility, in an appropriate setting, and at an appropriate level of care for the **treatment** of the patient's medical condition;
- provided only for an appropriate duration of time.

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, traditional Chinese 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 that is part of the medical network **you** are entitled to use for **treatment** covered by **your plan**. The medical network **you** are entitled to use is stated on **your Certificate of Insurance**, **network card** or **smartphone application**.

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.

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

Out-of-network penalty
The additional **co-insurance we** will apply to **your claim** settlement amount when **you** receive **your treatment** at a **medical services provider** that **you** are not 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 venous 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**.

Pharmacy

A **medical services provider** qualified and licensed to prepare and dispense medicine under the laws and regulations of the country in which it is located.

Plan

The Flex **plan** or **Primary Benefits plan** on which **you** and **your eligible dependants** are covered.

Plan holder

Your employer, stated as the **plan holder** 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**.

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** 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

Health tests, screening and/or clinical procedures specifically designed for disease prevention and early detection that are stipulated by the **DHA**, including initial diabetes screening.

Primary Benefits plan

In accordance with the laws of Dubai and the various circulars and guidelines issued by the **DHA**, the **Primary Benefits plan** is the **insurer's** equivalent to the **DHA** Essential Benefits plan, which sets out the minimum benefits required for private health insurance plans in the Emirate of Dubai. The **table of benefits** for the **Primary Benefits plan** is set out on pages 30-32 of this **agreement**.

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.

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 anniversary date of **your plan** as shown on **your Certificate of Insurance**, normally the anniversary of **your** original **date of entry** to the **plan**.

Restricted Network 3

The **medical services providers** listed as being within NextCare's **Restricted Network 3**. For a list of these **medical services providers** go to nextcarehealth.com.

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 **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 in this **agreement** that sets out the benefits covered by each **plan**.

Temporary trip

A trip for business and/or recreational purposes, which has a defined return date and is for a period that is no longer than the maximum duration specified for **your area of cover**. If **your treatment** extends beyond the end of **your** trip's specified return date, **your cover** will cease at the end of the term defined in **your area of cover** wording.

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.

Unused premium

The amount of **premium** that is attributable to the period from the date after the date of cancellation, up to the date before the next **premium due date**.

In the event of a refund of **unused premium** being eligible, the **unused premium** amount refunded (using an annually paid **plan** as an example) will be the annual **premium** paid divided by 12 and multiplied by the number of whole calendar months remaining in the **period of cover**. If the **plan** is cancelled part way through a month, an additional amount, equal to one twelfth of the annual **premium** paid, multiplied by the proportion of days without cover in the calendar month of cancellation will also be paid.

For example, if the annual **premium** for an **insured person** is US$3,000, the **period of cover** is 1st January to 31st December 2020, and the **insured person** leaves the **plan** on 27th September 2020, the **unused premium** will be US$775, as: -

- ((US$3,000 / 12) x 3) = US$750 for the three whole months without cover (October, November and December); added to -
- ((US$3,000 / 12) x 0.1) = US$25 for the three days in September without cover (the 0.1 calculated in this example by dividing 3 (the days in September without cover, *ie* the 28th, 29th and 30th) by the total number of days in September (30))

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**.

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