

دبي للتأمين
DUBAI INSURANCE



ELITE EMPLOYEE PLAN AGREEMENT

For all corporate Global Health Elite plan clients whose period of cover starts on or after **1st January 2012**



GLOBAL HEALTH[®]
Health Insurance for Expatriates

YOUR PLAN AGREEMENT

THANK YOU FOR CHOOSING A GLOBAL HEALTH ELITE PLAN

We want to provide you with an insurance plan you can rely on, so it is important that you fully understand the scope of the cover that your employer has provided for you. In this plan agreement we explain what is - and what is not - covered by your Global Health Elite plan.

This agreement also contains important information about how to make a claim and what to do in an emergency.

Please spend time looking through your agreement to ensure that you understand the cover we are providing.

CONVENIENCE AT YOUR FINGER-TIPS

This PDF agreement has been prepared to enable you to navigate directly to indexed content, without having to scroll through the whole document. Simply display the index by clicking the bookmark icon in the left-hand margin.

You will also find everything you need on our web site:

Web site **www.globalplans.ae**

Form & literature downloads **www.globalplans.ae/webworks**

All web addresses in this document are live. Simply click on a link, and you will be taken directly to the web.

And of course, we are always on the end of the telephone to answer queries, or deal with your claim:

Customer Services + **971 4 2697706**

Claims Team + **971 4 2697708**

Neuron Network **800 4408** (UAE) +**971 4 34 14770** (Within GCC)

Emergency Medical Assistance + **44 1243 621155** (Outside GCC)

PRE-AUTHORISATION REQUIREMENTS

IN-PATIENT AND DAY-PATIENT TREATMENT

It is a condition of the Global Health **plan agreement** that **we** only pay for **in-patient** and **day-patient treatment**, when it has been authorised by **us** in advance. By in advance, **we** mean BEFORE **you** have been admitted to **hospital**.

As soon as **you** know **you** need to be admitted to **hospital** **you** must contact **us** for pre-authorisation. If it is a medical emergency that occurs outside UK working hours, **you** must contact the **Assistance Service**. Full instructions about this procedure are stated on **your** Global Health Membership Card.

If you do not contact us in advance, we reserve the right to decline your claim, or to pay only 80% of the cost of eligible benefits. Please note that if you contact us less than 48 hours in advance of your admission we may be unable to authorise your treatment in time and you may be required to pay for the treatment yourself and then submit a claim to us for reimbursement.

In the case of an emergency, where it is not reasonably possible for you to contact us in advance, you must contact us within 72 hours to ensure that no payment penalty will apply to your claim.

Upon receipt of **your** call **we**, or the **Assistance Service**, will, when appropriate, authorise the proposed **treatment** and issue any necessary guarantee to the **hospital** and make arrangements to settle **your hospital** bill direct.

TREATMENT FOR CANCER, PSYCHIATRIC CONDITIONS, HOME NURSING AND REHABILITATION

Pre-authorisation is required for all **treatment** of any kind for cancer, psychiatric conditions, and for the home nursing and rehabilitation benefits. **We** will not pay for any **treatment** costs that have not been authorised in advance by **us**.

TREATMENT RECEIVED IN LONDON AND THE USA

Pre-authorisation is required for ALL **treatment** of any kind in the **London area**, and, (if **you** have Area Two or Area Three cover), in the USA. **We** will not pay for any **treatment** costs incurred in the **London area**, and in the USA that have not been authorised in advance by **us**.

DUBAI INSURANCE COMPANY PSC

Dubai Insurance Company psc is the **insurer** of **your** Global Health **plan**.

CONTACT DETAILS

Global Plans Team,
Dubai Insurance Company,
PO Box 3027, Dubai,
United Arab Emirates.
Enquiries: + 971 4 2697706
Claims: + 971 4 2697708
Fax: + 971 4 2691304
claims@globalplans.ae
www.globalplans.ae

**HOW TO CONTACT NEURON IF YOU HAVE A
NEURON NETWORK CARD**
Medical Provider Network:
Neuron LLC,
PO Box 72071, Dubai,
United Arab Emirates.
Helpline (Toll Free): 800 4408
Helpline (Non-Toll Free): + 971 4 3414770
Fax lines:
General: +971 4 382 3699
In-Patient: +971 4 382 3610
Out-Patient: +971 4 382 3620
www.neuron.nu

**CONTACTING THE ASSISTANCE SERVICE IN AN
EMERGENCY**
Assistance Service
(medical emergencies only):
24 hour emergency number:
+ 44 1243 621155
24 hour email:
cegagroup@globalplans.ae

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1. THE GLOBAL HEALTH PLAN AGREEMENT

This Global Health **plan agreement** is subject to the terms, conditions and exclusions of the **Master Certificate of Insurance** we issue to **your employer**. A copy of the **Master Certificate of Insurance** is available from **your employer**.

Your cover is also subject to the terms and conditions and exclusions contained within this **agreement**, and to any **special terms** stated on **your certificate of insurance**.

ELIGIBILITY TO JOIN YOUR EMPLOYER'S GLOBAL HEALTH PLAN

Eligibility to join **your employer's Global Health plan** is as stated on **your employer's application form**.

If **you** are eligible to join **your employer's Global Health plan**, you must join the **plan** at the first available opportunity.

By the **first available opportunity** we mean:

- At the commencement date of **your employer's plan** or on the date on which **you** commence employment with **your employer** if later, or,
- On the date on which **you** receive a promotion to a position within the company which entitles **you** to join **your employer's plan**.

Your eligible dependants must also join at the same time as **you** join.

If **you** or **your dependants** do not join **your employer's plan** at the first available opportunity **we** reserve the right to refuse cover or to only offer cover at **special terms**.

BOLD WORDS

Words written in **bold type** have a specific meaning relevant to this **agreement**. Such words are defined within the definitions section of this **agreement**.

THE PURPOSE OF YOUR PLAN

Insurance policies provide cover against an unexpected event happening after the start of **your policy** i.e. **your date of entry**. With health insurance this means cover for the cost of private medical **treatment** for unforeseen medical conditions first manifesting themselves after **your date of entry**.

Your plan is not intended to cover conditions which **you** already have before **your date of entry**, or which are related to conditions **you** have had before **your date of entry**. These are called **pre-existing conditions** and **related conditions**.

YOUR OBLIGATION TO DISCLOSE ALL FACTS RELATING TO YOUR OWN, AND TO 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**.

Special terms are exclusions or conditions that **we** may apply to **your cover** on joining the Global Health **plan**, or on transfer to another Global Health **plan** or **area of cover**.

We may accept **your application** with or without **special terms**, or **we** may refuse to accept **your application** at **our** sole and complete discretion and without being required to give any reason for **our** decision.

If **you** submit a **claim** for the **treatment** of any **pre-existing condition** or **related medical condition** which **you** omitted to tell **us** about on **your application form**, or **you** omitted to tell **us** everything about, **we** will refuse to pay that **claim**.

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

Please therefore take the greatest care to ensure that not only is **your application form** completed fully and accurately, but also that **you** have not withheld any facts which may have some effect on the terms upon which **we** accept **your application** for cover.

If after completing, signing and dating **your application form** any changes occur in the facts **you** have given **us**, such as a change in **your** state of health or in the state of health of any of **your dependants**, **you** must tell **us** in writing about the change, and **we** reserve the right to decline to accept **your application** or to accept **your application** with **special terms**.

COMPLETING YOUR GLOBAL HEALTH APPLICATION FORM

Your completed, signed and dated **application form** is an integral and crucial part of **your Global Health plan agreement** with **us** and the cover **we** provide.

When **you** apply for cover under the Global Health **plan** **you** must ensure that **your application form** has been fairly, fully, and accurately completed, and that **you** have made a full disclosure of all the facts relating to **your** health and to the health of all **your dependants** for whom cover is required.

Your Global Health plan will not cover medical conditions, or any **related conditions** for which symptoms have appeared prior to the commencement of cover, irrespective of whether any medical **treatment** or advice was sought.

If **you** or any of **your dependants** are suffering from any symptoms at the time of making **your application** **you** must declare these.

We will not pay benefit for any medical **treatment** subsequently required to investigate or treat any condition relating to symptoms suffered prior to joining the Global Health **plan**.

Once **your** Global Health application has been submitted to **us** it will become **our** property and cannot be returned.

PRE-EXISTING CONDITIONS AND RELATED CONDITIONS

Your Global Health plan does not cover the **treatment** of **pre-existing conditions** and **related conditions**.

A **pre-existing condition** means any disease, illness or injury for which:

1. **You** have received medication, advice or **treatment**; or
2. **You** have experienced symptoms;

whether the condition has been diagnosed or not, at any time before **your date of entry** to the Global Health **plan**.

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

AGE LIMITS

If **you** have an underwritten **plan**, **you** must be under 65 years of age at the commencement date of **your Global Health plan**.

APPLYING FOR COVER FOR YOUR ELIGIBLE DEPENDANTS

Provided **your** dependants are also eligible to join **your employer's plan**, **you** may apply for cover on behalf of **your** spouse or partner, (provided they are under 65 years of age), and/or on behalf of **your** unmarried children, (provided they are aged less than 18 years old, or less than 25 years old if in continuous full-time education). **We** reserve the right to request and receive proof of a dependent child being in full-time education. If **you** apply to add **your** new spouse or partner and/or dependent children after **your date of entry**, **you** must complete a new **application form** on their behalf. The new **application form** must be submitted to **us** by **your** employer and received by **us** within 30 days of **your** dependant becoming **your** spouse, partner or dependant child.

COMMENCEMENT OF YOUR COVER

Subject to **you** being eligible to join **your employer's plan**, **your Global Health plan** 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 until **we** have received payment of **your** premium, as invoiced by **us**, from **your employer**.

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 USA becomes **your country of residence** 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 the USA.

2. THE COVER PROVIDED BY YOUR GLOBAL HEALTH PLAN

Your Global Health plan insures **you** against the cost of the necessary, **recognised medical treatment** of **acute conditions** covered by **your plan** and received during **your period of cover**.

An **acute condition** means 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.

COVER FOR CHRONIC CONDITIONS

Your Global Health plan covers **treatment** of an **acute** exacerbation of a **chronic condition**. However, **you** are not covered for the cost of **treatment** that is aimed at maintaining or controlling a **chronic condition** except as stated in the **table of benefits** in respect of the Silver, Gold and Platinum **plans**.

REASONABLE AND CUSTOMARY CHARGES

We will only pay **reasonable and customary** charges. **Reasonable and customary** means the charge that would typically be made for **your treatment** by medical service providers in the country in which **you** receive **your treatment**. If the cost of **your treatment** is more than the charge that would typically be made by medical service providers, in the country in which **you** receive **your treatment**, **we** will only pay up to the amount which is typically charged in that country. In the event of a dispute, **we** will identify the amount typically charged for **your treatment** by medical service providers in the country in which **you** receive it, by obtaining three quotations and taking a mean average of these three quotations.

MEDICALLY NECESSARY AND MEDICALLY SUPERVISED TREATMENT

We will only pay for **treatment** received during **your period of cover** that is **medically necessary** and supervised by a **medical doctor**. By **medically necessary** **we** mean **treatment** that is medically appropriate and necessary to treat a condition that is covered under the terms and conditions of this **agreement**, and which is consistent with UK medical practice and guidelines regarding its type, frequency and duration. The UK guidelines used for the purpose will be those published by the National Institute for Health and Clinical Excellence in the UK.

We will only pay for **treatment** carried out by a qualified **medical doctor** or qualified **medical practitioner** to whom **you** have been referred by a **medical doctor**.

THE BENEFITS PROVIDED BY EACH GLOBAL HEALTH PLAN

The following **Table of Benefits** sets out the cover provided by each Global Health **plan**. Global Health offers four levels of cover - the Platinum **plan**, the Gold **plan**, the Silver **plan** and the Bronze **plan**. The **plan** **you** have bought is as stated on **your certificate of insurance**. Please familiarise **yourself** with the benefits that apply to **your plan**.

We will pay only for the benefits stated in the **Table of Benefits** of the Global Health **plan** **you** have bought. If **you** incur costs for benefits not covered

by the Global Health **plan you** have bought, **you** will have to pay these costs **yourself**. The maximum amount **we** will pay for certain benefits is limited. If **you** incur costs in excess of the limits stated in the **Table of Benefits** of the Global Health **plan you** have bought **you** will have to pay the difference.

Where the term **full refund** appears, please note that this is subject to the charges being **reasonable and customary**. **Full refund** also means **full refund** subject to any annual and/or life-time limits and any applicable **excess** and/or **co-insurance**.

There are life-time limits on the amount **you** can **claim** in respect of the following benefits – psychiatric **treatment**, compassionate home travel, **hospice** care, HIV/AIDS and, if **you** have the Gold or Platinum **plan**, the well-child benefit and, if **you** have the Platinum **plan**, the infertility investigations benefit. This means that the life-time limit is the maximum amount **we** will pay in respect of that particular benefit during **your** life-time. If **your** cover ceases for any reason, **your** entitlement to benefit ceases from the date on which **your** cover ceases. **Claims you** make from any life-time limit are subject to the overall annual **plan** limit for the **plan you** are insured by.

Your plan's benefits and the explanatory notes show which **treatment** costs and benefits **you** are covered for, subject always to the terms, conditions, definitions and exclusions stated in this **agreement** and on **your certificate of insurance**.

All the benefit limits in the following **Table of Benefits** and the explanatory notes are set out in sterling, United States dollars, euros, and UAE dirhams. The currency in which **you** pay **us your premiums** is the currency that applies to **your** cover. For example, if **you** pay **us your premiums** in sterling, the sterling benefit limits will apply.

TABLE OF BENEFITS

	BRONZE	SILVER	GOLD	PLATINUM
TOTAL ANNUAL BENEFIT LIMIT PER INSURED PERSON This is the overall maximum limit to the amount that you can claim during any one period of cover .	£625,000 or \$1,000,000 or €940,000 or AED3,670,000	£1,250,000 or \$2,000,000 or €1,875,000 or AED7,340,000	£1,560,000 or \$2,500,000 or €2,340,000 or AED9,175,000	£1,560,000 or \$2,500,000 or €2,340,000 or AED9,175,000
IN-PATIENT & DAY-PATIENT TREATMENT				
In-patient and day-patient treatment when it is medically necessary for you to occupy a hospital bed to receive treatment which is covered by your plan . We pay for hospital accommodation charges, surgeons', anaesthetists' and doctors' fees, nursing care, drugs and surgical dressings, theatre charges and intensive care, pathology, X-Rays, scans, oncology, diagnostic tests and physiotherapy. The hospital accommodation charges we pay are limited to the hospital's charge for a standard single room with an en-suite bathroom. We do not pay for personal items such as telephone calls, newspapers, and guest meals. We will only pay hospital charges for the period that it is medically necessary for you to stay in hospital .	Full refund of costs that have been authorised in advance by us or the Assistance Service	Full refund of costs that have been authorised in advance by us or the Assistance Service	Full refund of costs that have been authorised in advance by us or the Assistance Service	Full refund of costs that have been authorised in advance by us or the Assistance Service
In-patient emergency dental treatment This means emergency restorative dental treatment required to restore sound, natural teeth following an accident covered by your plan which necessitates your admission to hospital for at least one night. The dental treatment must be received within 15 days of the accident .	Up to £3,000 or \$4,800 or €4,500 or AED17,616 per period of cover	Up to £5,000 or \$8,000 or €7,500 or AED29,360 per period of cover	Up to £8,000 or \$12,800 or €12,000 or AED46,976 per period of cover	Full refund
Parent accommodation whilst a child is in hospital When a child under 18 years of age who is named as an insured person on the certificate of insurance receives treatment that is covered by their plan the hospital accommodation costs of one parent will also be covered provided the parent is also covered by a Global Health plan .	Full refund	Full refund	Full refund	Full refund
Hospital cash benefit Payable for each night spent in a hospital where you receive treatment that would have been covered by your plan and where no charge is made by the hospital . Benefit is restricted to a maximum of 60 nights during any period of cover .	£25 or \$40 or €37.50 or AED147 per night	£50 or \$80 or €75 or AED294 per night	£100 or \$160 or €150 or AED588 per night	£220 or \$350 or €330 or AED1,300 per night
ORGAN AND BONE MARROW TRANSPLANTS				
Heart, Kidney, Liver, Lung, Heart and lung, and bone marrow only We will pay for the cost of a heart, kidney, liver, lung, heart and lung or bone marrow transplant including all costs incurred whilst hospitalised, and all related out-patient treatment required prior to and after the transplant. We do not cover any costs associated with the acquisition of the organ, or any of the donor's costs. We only pay for transplants carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.	Full refund	Full refund	Full refund	Full refund
ONCOLOGY				
We will pay for: - Oncology (i.e. any treatment for cancer) required on an in-patient or day-patient basis, - Radiotherapy, and - Chemotherapy.	Full refund in respect of all eligible costs that have been authorised in advance by us	Full refund in respect of all eligible costs that have been authorised in advance by us	Full refund in respect of all eligible costs that have been authorised in advance by us	Full refund in respect of all eligible costs that have been authorised in advance by us
Out-patient follow up consultations and tests We will pay for medically necessary follow up consultations and tests received for cancer within your period of cover . All costs must be authorised in advance by us .	Full refund	Full refund	Full refund	Full refund

TABLE OF BENEFITS (cont.)

	BRONZE	SILVER	GOLD	PLATINUM
PSYCHIATRIC TREATMENT				
Life-time limit for psychiatric treatment This limit applies in respect of in-patient, day-patient and out-patient treatment combined.	Up to £25,000 or \$40,000 or €37,500 or AED146,800	Up to £30,000 or \$48,000 or €45,000 or AED176,160	Up to £40,000 or \$64,000 or €60,000 or AED234,880	Up to £50,000 or \$80,000 or €75,000 or AED293,600
In-patient psychiatric treatment We pay for in-patient and day-patient treatment in a recognised psychiatric unit of a Hospital . Cover is limited to 30 days per period of cover . This benefit is available after you have been insured by a Global Health Elite plan for a continuous period of 24 months. All treatment must be administered under the direct control of a registered psychiatrist and must be authorised by us in advance.	Up to the life-time limit for psychiatric treatment	Full refund within the life-time limit for psychiatric treatment	Full refund within the life-time limit for psychiatric treatment	Full refund within the life-time limit for psychiatric treatment
Out-patient psychiatric treatment We pay for specialist psychiatric consultations with a registered psychiatrist when you have been referred by a medical doctor . Cover is limited to 10 consultations per period of cover . This benefit is available after you have been insured by a Global Health Elite plan for a continuous period of 24 months. All treatment must be authorised in advance by us . NB: We do not pay for drugs prescribed for out-patient psychiatric treatment	Full refund if post-hospital treatment within the life-time limit for psychiatric treatment	Full refund within the life-time limit for psychiatric treatment	Full refund within the life-time limit for psychiatric treatment	Full refund within the life-time limit for psychiatric treatment
ROAD AMBULANCE CHARGES				
We will pay for 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 it is medically necessary for you to travel to the hospital by local road ambulance.	Full refund	Full refund	Full refund	Full refund
OUT-PATIENT TREATMENT				
Emergency ward treatment Emergency treatment covered by your plan and received at a hospital when it is not necessary for you to be admitted as an in-patient or day-patient .	Not covered	Full refund	Full refund	Full refund
Out-patient surgical procedure	Full refund	Full refund	Full refund	Full refund
GP and specialist consultations , prescribed drugs and dressings, pathology, scans, radiology and diagnostic tests received as an out-patient .	Full refund if post-hospital treatment .	Full refund	Full refund	Full refund
Advanced diagnostic Tests MRI, CAT (CT) and PET scans. NB. We will only pay for MRI and CAT (CT) scans performed on the advice of a medical doctor . We will only pay for PET scans performed on the advice of a specialist . The specialist's referral letter will be required.	Full refund if post-hospital treatment .	Full refund	Full refund	Full refund
Treatment by a Chiropractor, Osteopath, Homeopath, or Acupuncturist We will only pay for these treatments when you have been referred for treatment by a medical doctor . The medical doctor's referral letter will be required. The referral letter is only valid for the same or related condition for a period of three months from the date that the letter was issued. Cover is limited to a maximum of TEN sessions per period of cover in respect of ALL treatment types. If your condition becomes chronic and on-going treatment is aimed at maintaining it rather than curing it, no further payments will be made.	Covered only if post-hospital treatment (maximum of 10 sessions)	Full refund (maximum of 10 sessions)	Full refund (maximum of 10 sessions)	Full refund (maximum of 10 sessions)

TABLE OF BENEFITS (cont.)

	BRONZE	SILVER	GOLD	PLATINUM
OUT-PATIENT TREATMENT (cont.)				
Traditional Chinese medicine Limited to traditional Chinese medicine practitioners registered to practice in China only.	Not covered	Up to £20 or \$32 or €30 or AED118 per consultation, and a maximum of ten consultations per period of cover .	Up to £20 or \$32 or €30 or AED118 per consultation, and a maximum of ten consultations per period of cover .	Up to £20 or \$32 or €30 or AED118 per consultation, and a maximum of ten consultations per period of cover .
Physiotherapy We will pay for treatment by a fully qualified and registered physiotherapist only when you have been referred for treatment by a medical doctor . The medical doctor's referral letter will be required. The referral letter is only valid for the same or related condition for a period of three months from the date that the letter was issued. We will pay for a maximum of TEN standard sessions per claim . After ten standard sessions of physiotherapy treatment has been administered we will only pay for further sessions relating to the same condition if they have been authorised in advance by us . A further doctor's report will be required after each 10th session. We will not pay more than the benefit limit stated opposite, regardless of the number of physiotherapy sessions received, or the number of conditions treated. If your condition becomes chronic and ongoing physiotherapy is aimed at maintaining, rather than curing it, no further payments will be made.	Up to £625 or \$1,000 or €950 or AED3,700 per period of cover for post-hospital treatment only	Up to £1,575 or \$2,500 or €2,350 or AED9,175 per period of cover	Up to £3,125 or \$5,000 or €4,750 or AED18,350 per period of cover	Full refund
Chronic conditions We will pay for regular consultations, with a medical doctor , tests and prescribed medication required to monitor and maintain the stability of a chronic condition that is not a pre-existing condition , up to the annual benefit limit stated opposite. The chronic conditions benefit is limited to the above treatments and does not include other medical treatments , e.g., physiotherapy aimed at maintaining stability. If you have more than one chronic condition , the limit opposite applies to all claims for chronic conditions , and not to each chronic condition . For example, if you have a dollar Silver plan and you develop diabetes and asthma, the total you can claim in respect of both conditions during your period of cover is a maximum amount of \$10,000. The treatment of an acute exacerbation of a chronic condition that is not a pre-existing condition is not subject to this limit.	Not covered	Up to £6,250 or \$10,000 or €9,375 or AED36,700 per period of cover	Up to £9,375 or \$15,000 or €14,075 or AED55,050 per period of cover	Full refund
WELL-BEING BENEFITS				
Well-being examination and tests Once you have been insured by the same plan type for a continuous period of twelve months we will pay towards the cost of the following preventive health checks:- a general annual medical check-up as per our well-being medical examination report form , an annual colon cancer test, bone densitometry, an annual cervical smear test and mammogram for women, an annual prostate cancer test for men. The Well-being benefit is not available to children insured as dependants under your policy.	Not covered	Up to £160 or \$250 or €235 or AED920 per period of cover	Up to £250 or \$400 or €375 or AED1,468 per period of cover	Up to £345 or \$550 or €520 or AED2,020 per period of cover
Vaccinations Once you have been insured by the Gold or Platinum plan for a continuous period of twelve months we will pay for immunisations, booster injections and travel vaccinations recommended by a medical doctor , nurse or by the recognized Health Authority in your country of residence or any country that you plan to visit. The cost of the consultation with the medical professional who is required to administer the vaccination is included within this benefit. The vaccinations benefit is not available to children insured as dependants under your policy.	Not covered	Not covered	£32 or \$50 or €47 or AED185 per period of cover	£65 or \$100 or €95 or AED370 per period of cover

TABLE OF BENEFITS (cont.)

	BRONZE	SILVER	GOLD	PLATINUM
WELL-BEING BENEFITS (CONT.)				
Annual optical examination Once you have been insured by the Platinum plan for a continuous period of twelve months we will pay towards the cost of an annual optical examination up to the annual benefit stated. The annual optical examination benefit is not available to children insured as dependants under your policy.	Not covered	Not covered	Not covered	Up to £32 or \$50 or €47 or AED185 per period of cover
Well-child benefit Once a child insured as a dependant under your policy has been insured by the Gold or Platinum plan for a continuous period of 12 months we will pay towards the cost of routine vaccinations and developmental check-ups. The 12 month waiting period does not apply to children born to a mother insured by the Gold or Platinum plan for at least 12 months, and added to the same plan as the mother, within the first 28 days of life.	Not covered	Not covered	Up to lifetime limit of £160 or \$250 or €240 or AED920	Up to lifetime limit of £310 or \$500 or €460 or AED1,835
HIV & AIDS				
Once you have been insured by the same plan type for a continuous period of 24 months, we will pay towards the cost of treatment arising from or related to Human Immunodeficiency Virus (HIV) and/or HIV-related illness, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) up to the annual benefit limit stated opposite and for a maximum period of 5 years, provided the HIV virus was contracted after your date of entry .	Up to £3,125 or \$5,000 or €4,650 or AED18,350 per period of cover for in-patient or day-patient treatment only	Up to £3,125 or \$5,000 or €4,650 or AED18,350 per period of cover	Up to £3,125 or \$5,000 or €4,650 or AED18,350 per period of cover	Up to £6,250 or \$10,000 or €9,375 or AED36,700 per period of cover
REHABILITATION				
We will pay for in-patient rehabilitation carried out under the control and supervision of a specialist in a recognised rehabilitation hospital or unit only when it immediately follows in-patient treatment covered by your plan . The rehabilitation 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 . All treatment must be authorised in advance by us .	Up to £1,575 or \$2,500 or €2,350 or AED9,175 per period of cover	Up to £3,125 or \$5,000 or €4,750 or AED18,350 per period of cover	Up to £4,675 or \$7,500 or €7,000 or AED27,525 per period of cover	Up to £6,250 or \$10,000 or €9,375 or AED36,700 per period of cover
HOME NURSING				
We will pay for the medical services of a qualified nurse to treat you in your own home when it is medically necessary and relates directly to an illness or injury covered by your plan . Cover for nursing at home is restricted to a maximum of 12 weeks per year. We do not pay for nursing at home that is required for domestic reasons. All treatment must be authorised in advance by us .	Full refund up to a maximum of 12 weeks per period of cover	Full refund up to a maximum of 12 weeks per period of cover	Full refund up to a maximum of 12 weeks per period of cover	Full refund up to a maximum of 12 weeks per period of cover
HOSPICE & PALLIATIVE CARE				
We will pay towards the palliative care of a medical condition covered by your plan up to the following life-time limits:	Up to a life-time limit of £12,500 or \$20,000 or €18,750 or AED 73,500	Up to a life-time limit of £15,625 or \$25,000 or €23,425 or AED 91,875	Up to a life-time limit of £31,250 or \$50,000 or €46,850 or AED 183,750	Up to a life-time limit of £46,875 or \$75,000 or €70,275 or AED 275,160

TABLE OF BENEFITS (cont.)

	BRONZE	SILVER	GOLD	PLATINUM
MEDICAL AIDS AND DEVICES				
<p>We will pay towards the cost of supplying, fitting or hiring instruments, apparatus or devices which are medically prescribed as an aid to your function or capacity, such as crutches, wheelchairs, orthopaedic supports/braces, stoma supplies and compression stockings, only when it immediately follows in-patient, day-patient or emergency ward treatment covered by your plan. Costs for medical aids that form part of the care of a chronic condition are not eligible for cover under this benefit.</p>	Up to £95 or \$150 or €140 or AED550 per period of cover	Up to £160 or \$250 or €240 or AED920 per period of cover	Up to £325 or \$500 or €475 or AED1,835 per period of cover	Up to £625 or \$1,000 or €950 or AED3,700 per period of cover
PROSTHESES				
<p>Prosthetic implants and appliances We will pay for 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. We will also pay for a knee brace if it is an essential part of a surgical operation for the repair to a knee ligament, and for a spinal support if it is an essential part of a surgical operation to the spine.</p>	Full refund	Full refund	Full refund	Full refund
<p>Prosthetic devices We will pay for external prosthetic body parts, such as prosthetic limbs, fitted at the time of a surgical operation covered by your plan.</p>	Up to £325 or \$500 or €475 or AED1,835 per device	Up to £625 or \$1,000 or €950 or AED3,670 per device	Up to £940 or \$1,500 or €1,410 or AED5,505 per device	Up to £1,575 or \$2,500 or €2,350 or AED9,175 per device
PREGNANCY & CHILDBIRTH BENEFITS				
<p>Complications of pregnancy After you have been covered by the same plan for a continuous period of 12 months we will cover in-patient or day-patient treatment necessary as a direct result of a complication of pregnancy. There is no cover for treatment received within the first 12 months of your plan. NB: No cover is provided under this benefit for childbirth or emergency caesarean section.</p>	Up to £3,000 or \$4,800 or €4,500 or AED17,616 per period of cover	Up to £4,000 or \$6,400 or €6,000 or AED23,488 per period of cover	Up to £9,375 or \$15,000 or €14,065 or AED55,050 per pregnancy in total for complications of pregnancy and childbirth necessitating an emergency surgical procedure	Full refund
<p>Childbirth necessitating an emergency surgical procedure After you have been insured under the Gold or Platinum plan for a continuous period of 12 months we will pay for the cost of surgeon, anaesthetist and theatre fees for childbirth which necessitates an emergency surgical procedure and for any additional accommodation charges incurred as the result of the surgical procedure. Note: any charges incurred as the result of normal childbirth will be paid from the routine maternity benefit</p>	Not covered	Not covered		Full refund
<p>Routine maternity care and childbirth After you have been covered by the Gold or Platinum plan for a continuous period of 12 months, we will pay towards the cost of routine pre-natal and post natal treatments and examinations, and towards the cost of natural childbirth or childbirth by elective caesarean section. We will also pay for out-patient treatment you receive as a result of a complication of pregnancy. There is no cover for costs incurred within the first 12 months of your plan. Pre-natal tests are limited to blood tests, urine tests, Downs Syndrome Screening, Combined Test, Triple Test, Quadruple test, testing for gestational diabetes, foetal echocardiography recommended as part of a routine anomaly scan, blood pressure monitoring and foetal scans (up to a maximum of 3. There is no cover for 3-D or 4-D scans or for scan photographs).</p>	Not covered	Not covered	80% of costs up to a maximum of £4,000 or \$6,400 or €6,000 or AED23,488 per pregnancy	Full refund up to £7,500 or \$12,000 or €11,250 or AED44,040 per pregnancy

TABLE OF BENEFITS (cont.)

	BRONZE	SILVER	GOLD	PLATINUM
PREGNANCY & CHILDBIRTH BENEFITS (cont.)				
Cover for newborns We will pay the in-patient and day-patient accommodation and treatment charges for a child born to a mother who has been insured under the Silver, Gold or Platinum plan for at least 12 consecutive months. We will also pay for the accommodation cost of one parent to stay in hospital with the newborn child. Cover will be restricted to the first 28 days of life. After that an application form and neonatal questionnaire must be completed and submitted to us in respect of the newborn child. During the first 28 days of life we will pay for any necessary in-patient and day-patient treatment required relating to birth defects and congenital conditions . In the event of a multiple birth, the limit stated opposite is the maximum amount that can be claimed regardless of the number of children born.	Not covered	Up to £3,125 or \$5,000 or €4,750 or AED18,350 per pregnancy	Up to £46,875 or \$75,000 or €70,275 or AED275,625 per pregnancy	Up to £62,500 or \$100,000 or €93,750 or AED367,000 per pregnancy
Infertility investigations After you have been covered by the Platinum plan for a continuous period of 24 months we will pay for medically necessary investigations to establish the cause of infertility when they have been recommended by a specialist . This benefit does not include investigations for your spouse or partner unless they have also been insured under the Platinum plan for a continuous period of 24 months. In the event that both you and your spouse or partner require infertility investigations, the total amount payable in respect of both persons will not exceed the amount stated opposite. Note: This benefit does not include treatment for infertility such as assisted reproduction or IVF.	Not covered	Not covered	Not covered	80% of costs up to a lifetime limit of £1,575 or \$2,500 or €2,350 or AED9,175
OUT-PATIENT DENTAL BENEFITS				
Emergency out-patient dental treatment We will pay only for restorative dental treatment required to treat or replace sound, natural teeth lost or damaged following an accidental injury to the mouth. The dental treatment must be carried out by a dentist in a hospital emergency room or dental surgery, and it must be received within 72 hours of the accident . We do not pay for treatment that is required as a result of biting on food. We do not pay for damage sustained to crowns, dentures, bridge work or false teeth.	Not covered	Up to £310 or \$500 or €475 or AED1,835 per period of cover	Up to £625 or \$1,000 or €950 or AED3,700 per period of cover	Up to £940 or \$1,500 or €1,410 or AED5,505 per period of cover
Routine dental treatment After you have been insured under the Elite Gold or Platinum plan for 6 months you are covered for routine dental treatment , as set out below, subject to the excess stated in your certificate of insurance and up to the limits specified opposite. There is no cover during the first six months of your cover. Routine dental treatment means: – Screening (twice per year), i.e., the assessment of diseased, missing and filled teeth, including X-rays where necessary, – Preventive scaling, polishing, and sealing (once per year), – Fillings* (standard amalgam or composite fillings) and extractions, and – Root-canal treatment (but not the fitting of a crown following root-canal treatment). No other treatment is covered under the routine dental treatment benefit. *NB: We do not pay for gold or ceramic fillings.	Not covered	Not covered	Up to £600 or \$1,000 or €900 or AED3,670 per period of cover	Up to £1,575 or \$2,500 or €2,350 or AED9,175 per period of cover in total for routine dental treatment and complex dental treatment
Complex dental treatment After you have been insured under the Platinum plan for a continuous period of 12 months you are covered for complex dental treatment as defined below, up to the limit specified opposite. There is no cover during the first 12 months of your Platinum plan cover. Complex dental treatment means crowns, inlays, bridges and implants. No other treatment is covered by the complex dental treatment benefit.	Not covered	Not covered	Not covered	

TABLE OF BENEFITS (cont.)

	BRONZE	SILVER	GOLD	PLATINUM
EMERGENCY EVACUATION BENEFIT				
<p>Emergency evacuation If you, or any child covered by the Newborn benefit within the first 28 days of life, have a life-threatening condition covered by your plan which requires immediate in-patient treatment that cannot be adequately provided locally, the Assistance Service will arrange for you to be moved by air and/or by surface transportation, to the nearest hospital within your area of cover (excluding the U.S.A) where appropriate medical treatment is available. The Assistance Service retains the absolute right to decide whether your medical condition is life-threatening, whether or not the treatment could be adequately provided locally, where you are evacuated to and the means and method of the evacuation. We will only pay for your evacuation if all the arrangements have been authorised and made by the Assistance Service.</p> <p>We do not pay for any other costs related to your evacuation such as hotel accommodation charges.</p> <p>We do not pay for mountain rescue or rescue from ski slopes or for evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht.</p>	Full refund	Full refund	Full refund	Full refund
<p>Return airfare We will also pay for your economy return airfare for you to return to your country of residence following an emergency evacuation covered by your plan.</p>	Full refund	Full refund	Full refund	Full refund
<p>Travelling expenses of a companion We will also pay for the transportation costs of another person to accompany you on an emergency evacuation provided the Assistance Service has also authorised this in advance. We will also pay for their economy airfare back to your country of residence.</p>	Full refund	Full refund	Full refund	Full refund
<p>Accommodation expenses of a companion If your companion is required to stay with you whilst you receive in-patient treatment at a hospital we will pay towards their hotel accommodation. This benefit is limited to a maximum of 15 nights during your period of cover.</p>	Up to £45 or \$72 or €67.50 or AED265 per night	Up to £60 or \$96 or €90 or AED353 per night	Up to £75 or \$120 or €112.50 or AED441 per night	Up to £100 or \$160 or €150 or AED588 per night
<p>Compassionate home travel If a close family member dies during your period of cover and after you have been covered by your Global Health plan for at least 12 months, we will pay for your return economy airfare to attend the funeral. Travel must take place within 28 days of the date of death.</p> <p>A close family member means your spouse, parent, brother, sister, child or grand-child. This benefit is limited to a life-time limit of one claim per insured person.</p>	Full refund	Full refund	Full refund	Full refund
<p>Repatriation of mortal remains If you die as the result of a condition that is covered by your plan whilst you are outside your home country (and no claim has been made under the Burial or Cremation benefit) we will pay for the Assistance Service to transport your body or ashes to your home country or country of residence. We will only pay for costs that have been authorised in advance by the Assistance Service.</p> <p>This benefit is not available if a claim is made for burial or cremation at the place where you died.</p>	Up to £5,000 or \$8,000 or €7,500 or AED29,360	Up to £7,000 or \$11,200 or €10,500 or AED41,104	Up to £10,000 or \$16,000 or €15,000 or AED58,720	Up to £12,500 or \$20,000 or €18,750 or AED73,400

TABLE OF BENEFITS (cont.)

	BRONZE	SILVER	GOLD	PLATINUM
EMERGENCY EVACUATION BENEFIT (cont.)				
<p>Burial or cremation If you die as the result of a condition that is covered by your plan whilst you are outside your home country (and no claim has been made under the repatriation of mortal remains benefit) we will pay for you to be buried or cremated at the place where you died. We will only pay for costs that have been authorised in advance by the Assistance Service.</p> <p>We do not pay for the costs of a religious practitioner. There is no cover if you die in your home country.</p> <p>This benefit is not available if a claim is made for repatriation of mortal remains.</p>	Up to £1,000 or \$1,600 or €1,500 or AED5,875	Up to £1,000 or \$1,600 or €1,500 or AED5,875	Up to £1,000 or \$1,600 or €1,500 or AED5,875	Up to £1,000 or \$1,600 or €1,500 or AED5,875

PLAN LIMITS

The limits shown above are the maximum amounts **we** will pay after the application of any **excess** and **co-insurance**.

THE EXCESS - PER CLAIM

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

Your excess is applied to each **claim you** submit. A **claim** is defined as a course of **treatment** for a specific illness, injury, medical condition, dental condition or pregnancy.

However, if **your claim** is in respect of the **chronic conditions** benefit or for **out-patient** follow up consultations and tests received for cancer, **your excess** will be applied once per condition per **period of cover**.

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

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

For example, if you have Elite Gold (which has a 20% co-insurance and a limit of \$6,400 for routine maternity) and you have a \$100 excess, we will calculate payment on the following basis:

<ul style="list-style-type: none"> - If your covered routine maternity care costs total \$8,500 - \$8,500 (medical costs) x 80% = \$6,800 - \$100 (excess) = \$6,700. - Amount left exceeds \$6,400 (limit) - Payment = \$6,400 	<ul style="list-style-type: none"> - If your covered routine maternity costs are \$7,500 - \$7,500 (medical costs) x 80% = \$6,000 - \$100 (excess) = \$5,900 - Amount left is less than \$6,400 (limit) - Payment = \$5,900
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THE EXCESS - PER ANNUM

If **your excess** is per annum, **your excess** is applied once, per **period of cover**. We will not reimburse **you** for the first \$250 of eligible expenses **you** incur. However, once the aggregate total of eligible expenses **you** submit to **us** in any one **period of cover** exceeds \$250, **we** will reimburse **you** in respect of the eligible expenses exceeding \$250. For example if **you** have the Gold plan with an **excess** of \$250 per annum and **you** submit a **claim** for \$100 in respect of the well-being benefit and a **claim** for \$350 in respect of the routine dental benefit, and the treatment dates for both claims fall within the same **period of cover**, **we** will reimburse **you** \$450 (\$100 + \$350) less the excess of \$250. The total **you** receive would therefore be \$200.

Any subsequent eligible claims **you** submit in respect of **treatment** received within the same **period of cover** will be reimbursed in full and will not be subject to any further excess deduction. When **you** renew **your plan**, the annual **excess** will apply again in respect of **your new period of cover**. **You** must submit all eligible **claims** to **us** - even **claims** within **your annual excess** - as **we** will only start to reimburse **you** when the value of the eligible expenses **you** incur and submit to us as a **claim** exceeds **your annual excess**.

POST-HOSPITAL TREATMENT

Post-hospital treatment is **medically necessary** follow-up consultations, tests and/or **treatment** required on an **out-patient** basis following **in-patient** or **day-patient treatment** covered by **your plan** and received within the 90 day period following the date **you** are discharged from **hospital**.

3. YOUR AREA OF COVER

Your cover is restricted to the **area of cover** stated on **your certificate of insurance**. The available **areas of cover** are as stated below.

AREA ONE

Area One provides world-wide cover excluding the United States of America.

AREA ONE (ORCHID)

Area One (Orchid) provides world-wide cover excluding the United States of America.

If **you** live in Bali, China, Hong Kong, Macau, Taiwan, Singapore or Japan **you** must tell **us** and **you** must pay the Orchid rate.

AREA TWO

Area Two provides world-wide cover excluding the United States of America. However **we** will cover **you** in the United States during **temporary trips** **you** make to the USA during **your annual period of cover**.

A **temporary trip** means a trip **you** take to the United States of America for business or pleasure of not more than 45 days duration. Any trip of longer than 45 days is not a **temporary trip** and will not be covered by this insurance.

An Emergency Evacuation is not a **temporary trip** that is taken for business or pleasure. In the event that **you** suffer a **life-threatening condition** that cannot adequately be treated locally **you** will be evacuated to the nearest **hospital**, in a country other than the United States of America, capable of treating **your** condition.

Cover is only provided in accordance with the benefits of the **plan** stated on **your certificate of insurance** and no cover will be provided for **treatment** relating to a **pre-existing condition**.

The maximum amount **we** will pay in respect of **treatment** received in the USA is US\$100,000 in any one **period of cover**.

It is a condition of this agreement that all treatment costs incurred in the USA must be authorised in advance by us. We will not pay for any treatment costs that have not been authorised in advance by us.

AREA THREE

Area Three provides world-wide cover excluding the United States of America. However **we** will cover **you** in the United States during **temporary trips** **you** make to the USA during **your annual period of cover**.

A **temporary trip** means a trip **you** take to the United States of America for business or pleasure of not more than 90 days duration. Any trip of longer than 90 days is not a **temporary trip** and will not be covered by this insurance.

A **temporary trip** means a trip **you** take to the United States of America for business or pleasure of not more than 90 days duration. Any trip of longer than 90 days is not a **temporary trip** and will not be covered by this insurance.

An Emergency Evacuation is not a **temporary trip** that is taken for business or pleasure. In the event that **you** suffer a **life-threatening condition** that cannot adequately be treated locally **you** will be evacuated to the nearest **hospital**, in a country other than the United States of America, capable of treating **your** condition.

Cover is only provided in accordance with the benefits of the **plan** stated on **your certificate of insurance** and no cover will be provided for **treatment** relating to a **pre-existing condition**.

The maximum amount **we** will pay in respect of **treatment** received in the USA is US\$250,000 in any one **period of cover**.

It is a condition of this agreement that all treatment costs incurred in the USA must be authorised in advance by us. We will not pay for any treatment costs that have not been authorised in advance by us.

AREA FOUR (AFRICA AND THE INDIAN SUBCONTINENT)

This **Area of Cover** is only available to residents of **Africa and the Indian Subcontinent**. Cover is provided in all countries within **Africa and the Indian Subcontinent** as defined in page 27 of this **agreement**.

Cover outside **Africa and the Indian Subcontinent** is restricted to **emergency treatment you** receive whilst on a **temporary trip** to a **restricted country**. No cover is provided during trips (temporary or otherwise) to an **excluded country or area**.

Emergency treatment means essential **treatment**, covered by **your plan**, and required if **you** suffer an **accident** or a sudden and unforeseen illness **you** have never suffered from before. Cover is only provided in accordance with the benefits of the **plan** stated on **your certificate of insurance** and no cover will be provided in respect of any **pre-existing condition** or **related condition**, or any condition specifically excluded on **your certificate of insurance**. **We** will not pay for **treatment** if **you** have travelled outside **Africa and the Indian Subcontinent** knowing that **you** would require **treatment**.

Cover will only be provided if, in **our** opinion, the **treatment** was essential and could not reasonably have been delayed until **your** return to **Africa and the Indian Subcontinent**.

A **temporary trip** is a trip **you** take, for business or pleasure, of not more than 90 days duration. Any trip of longer than 90 days is not a **temporary trip** and will not be covered by this insurance.

A **restricted country** means a country outside **Africa and the Indian Subcontinent** and outside the USA, Canada, the Caribbean, and outside the **London area**.

An **excluded country or area** means the USA, Canada, all Caribbean countries and islands, and the **London area**.

The maximum benefit **we** will pay in respect of all **emergency treatment you** receive in **restricted countries** is £62,500 or US\$100,000 or €93,750 or AED367,000 per annual **period of cover**.

If **you** move outside **Africa and the Indian Subcontinent**, **you** will no longer be eligible for Area Four cover and **you** must apply to change **your area of cover** to Area One, Area Two or Area Three.

CONTINUING YOUR COVER WHEN YOU RETURN TO YOUR HOME COUNTRY

If **you** return to **your home country** **you** may continue to renew **your** cover provided that the local laws in **your home country** permit **you** to do so, and provided that **we** agree to offer cover in that country. **We** reserve the right to refuse to offer cover in certain countries.

RETURNING HOME TO THE UNITED STATES OF AMERICA

If **your home country** is the USA, **your** cover will automatically terminate from the date on which **you** return to **your home country** on a permanent basis.

4. MAKING A CLAIM

MAKING A CLAIM THROUGH THE NEURON NETWORK IF YOU HAVE A NEURON GLOBAL HEALTH CARD

If **you** have a Neuron card, **you** are entitled to use the Neuron regional network of clinics, pharmacies and hospitals for **treatment** that is eligible under the terms of **your plan**. These clinics, pharmacies and hospitals are referred to as **medical network providers**.

The name of the Neuron Network **you** are entitled to use is as stated on **your Certificate of Insurance** and on **your** Neuron card.

Full details of the **medical network providers** that form part of the Neuron Network **you** are entitled to use, can be found at www.globalplans.ae.

When **you** use a **medical provider** within the Neuron Network **you** are entitled to use, **you** simply present **your** Neuron Global Health card to the **medical network provider**.

If **your plan** has an **excess**, **you** must pay the **excess** amount to the **medical network provider** in respect of each **doctor's** consultation. The **medical network provider** will submit the bills for **your** consultation and **treatment** (less the **excess** amount **you** have paid) to Neuron for settlement.

Please note that **you** can only **claim** for **treatment** that is covered under the terms of **your plan**, so before **you** embark on a course of **treatment** with a **medical network provider** **we** strongly recommend that **you** call **us** or Neuron who can advise **you** whether the proposed **treatment** will be covered by **your plan**. Please note that if **your claim** is for **treatment** that is not covered by **your plan** **you** must repay to **us** the ineligible costs you have claimed.

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

OBTAINING PRE-AUTHORISATION FOR IN-PATIENT AND DAY-PATIENT TREATMENT, AND FOR ALL TREATMENT FOR CANCER

Pre-authorisation is also required for all **in-patient** and **day-patient treatment**, and for all **treatment** for cancer. Please contact **us** or Neuron as soon as **you** become aware that **you** need such **treatment**. **We** will not pay for **treatment** that has not been pre-authorised by **us** or by Neuron.

INELIGIBLE CLAIMS

Please note that if **your treatment** turns out not to be eligible under the terms of **your** cover, **we** will invoice **you** for the ineligible amount claimed, and **you** must repay this amount to **us** without delay.

OUR RIGHT TO WITHDRAW THE NEURON SERVICE AT ANY TIME

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

CONTACTING NEURON

Neuron LLC, PO Box 72071, Dubai, United Arab Emirates.

Helpline (Toll Free): 800 4408 Helpline (Non-Toll Free): + 971 4 3414770

Fax lines: General: +971 4 382 3699 In-Patient: +971 4 382 3610 Out-Patient: +971 4 382 3620 Web: www.neuron.nu

IF YOU DO NOT HAVE A NEURON CARD, OR IF YOU USE A MEDICAL PROVIDER OUTSIDE OF THE NETWORK YOU ARE AUTHORISED TO USE

You must follow the following procedures if **you** do not have a Neuron card, and/or **you** have a Neuron card but **you** are using a medical provider who is not part of the Neuron network **you** are authorised to use.

OBTAINING PRE-AUTHORISATION FOR ALL IN-PATIENT AND DAY-PATIENT TREATMENT

It is a condition of the Global Health **plan agreement** that **we** will only pay for **in-patient** or **day-patient hospital treatment**, that has been authorised in advance by **us**, or, if it is an emergency, by the **Assistance Service**. By in advance **we** mean BEFORE **you** have been admitted to **hospital**. If **you** do not obtain pre-authorisation for **in-patient** or **day-patient hospital treatment**, **we** reserve the right to decline **your claim** or to pay only 80% of the eligible **in-patient** or **day-patient hospital treatment** costs. Please note that if **you** contact **us** or the **Assistance Service** less than 48 hours in advance of **your** admission **we** may be unable to authorise **your treatment** in time and **you** may be required to pay for the **treatment yourself** and then submit a claim to **us** for reimbursement.

If it was not reasonably possible for **you** to contact **us** in advance of an **in-patient** or **day-patient** admission, provided **you** contact **us** within 72 hours of **your** admission, no **treatment** penalty will be applied.

OBTAINING PRE-AUTHORISATION FOR ALL TREATMENT FOR CANCER, PSYCHIATRIC TREATMENT, HOME NURSING AND REHABILITATION

You must contact **us** to pre-authorise all **treatment** for cancer, psychiatric conditions, and if **you** need to **claim** the rehabilitation or home nursing benefit. **We** will not pay for any **treatment** **we** have not pre-authorised.

OBTAINING PRE-AUTHORISATION FOR ALL TREATMENT RECEIVED WITHIN THE LONDON AREA OR IN THE USA

You must contact **us** to pre-authorise all **treatment** received within the **London area**, or in the United States of America if **you** have Area Two or Area Three cover. **We** will not pay for any **treatment** **you** receive within the **London area** or within the USA if **we** have not pre-authorised it.

HOW TO OBTAIN PRE-AUTHORISATION

As soon as **you** know **you** require **treatment**, contact **us** on:

+ 44 1276 486460 (**Our** lines are open between 6am and 6pm UK time on UK working days)

24-HOUR EMERGENCY NUMBER

In a medical emergency contact the **Assistance Service** on + 44 1243 621155.

IMPORTANT NOTE

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

MAKING A CLAIM FOR IN-PATIENT OR DAY-PATIENT TREATMENT

Upon receipt of **your** call **we** will immediately contact the **hospital** to obtain a 'Notification of Admission Form' which **we** require before **we** can confirm **your** cover and guarantee **your hospital treatment** costs. **We** will also ask **you** to complete a "Pre-Authorisation Claim Form" and to provide **your** consent for the release of medical information.

Upon receipt of a satisfactory "Notification of Admission" form from the **hospital**, a completed Pre-Authorisation Claim Form and any other information **we** may reasonably require, **we** can confirm whether or not the proposed **treatment** is covered by **your plan**, and if it is, **we** will confirm this to the **hospital** and authorise the **treatment** costs. **We** will then arrange for the authorised costs to be settled direct to the **hospital**, provided that **your**

treatment takes place during **your** current **period of cover**. If **your treatment** is due to take place after **your** current **period of cover** expires, **we** cannot authorise **your treatment** costs until after **you** have paid **your** renewal premium. If the proposed **treatment** is not covered by **your plan** **you** will be responsible for paying the **treatment** costs **yourself**.

MAKING A CLAIM FOR OUT-PATIENT TREATMENT

Out-patient treatment does not need to be pre-authorised by **us** in advance, however **we** strongly recommend that **you** contact **us** BEFORE **you** incur any costs to check that the course of **treatment your doctor or dentist** recommends is covered by **your plan**.

If **you** have a **claim** for **out-patient treatment**, please pay the medical bills and submit **your claim** to **us** in the following way:

We will require a fully completed claim form. **You** must complete Sections A and B of **our** Global Health claim form, and **your doctor or dentist** must complete and sign Section C.

We advise that **you** take a claim form with **you** when **you** visit **your doctor or dentist**. The **doctor or dentist** must fully complete all relevant parts of section C of the claim form and sign the declaration at the end.

The fully completed claim form must be sent to Dubai Insurance Company by post or courier together with the ORIGINAL itemised invoices AND receipts.

We cannot settle **your** claim without having a fully completed claim form and the original invoices and receipts for the expenditure for which **you** are claiming.

If **you** are claiming for physiotherapy, chiropractic **treatment**, acupuncture, homeopathy, osteopathy, **out-patient** psychiatric **treatment**, or an MRI or CAT(CT) scan **you** must also send **us** the written referral letter signed by **your medical doctor**.

If **you** are claiming for a PET scan, **you** must also send **us** the written referral letter signed by **your specialist**.

Upon receipt of **your** original **claim** documents and any other information **we** may reasonably require, **we** will confirm whether or not **your claim** is covered by **your plan** and, if it is, **we** will arrange reimbursement of all eligible expenses in accordance with the instructions **you** give **us** in Section B of **your claim** form.

CLAIMING YOUR WELL-BEING BENEFITS

You may make a **claim** for the well-being benefit once **you** have been insured by the Platinum **plan**, the Gold **plan** or the Silver **plan** for a continuous period of 12 months. The tests listed in the well-being examination and tests benefit in the **table of benefits** may be claimed once during any annual **period of cover**.

To make a **claim** **you** must first contact **us** for a copy of **our well-being medical examination report form**. **We** can mail this to **you**, or send it by fax or by e-mail. When **you** have received the form **you** must take it along to **your doctor**. The **doctor** who examines **you** must complete the **well-being medical examination report form** and return it to **us**. **We** will only make reimbursement in respect of those examinations and **diagnostic tests** listed on **our well-being medical examination report form** and in the **table of benefits**. Upon receipt of the **well-being medical examination report form** and the original receipts for the medical examination and the additional test(s) performed, **we** will make reimbursement to **you** in the normal way.

Your excess will be applied once **per period of cover** (irrespective of whether you have a per claim or a per annum excess) in respect of the well being section of **your plan**. So, if **you** are covered by the Platinum **plan**, and **you** claim for the well-being examination and tests benefit, and later, within the same **period of cover**, for vaccinations and an optical check-up, **we** will apply **your excess** only once.

The well-being benefit is not available to children insured as dependants under **your plan**.

For persons whose **date of entry** is prior to 1st January 2007, making a **claim** for the well-being benefit will not invalidate **your** entitlement to the no **claim** incentive set out on page 26 of this **agreement**.

CLAIMING YOUR WELL-CHILD BENEFIT

You may make a **claim** for the well-child benefit once **your** child has been insured by the Gold or Platinum **plan** for a continuous period of 12 months.

To make a **claim**, **you** must first contact **us** for a copy of **our** well-child claim form. **We** can mail this to **you**, or send it by fax or by email.

Upon receipt of the completed well-child claim form and the original receipts for the medical examination and/or vaccination(s). **We** will total **your** eligible costs, deduct **your excess**, and make settlement to **you** in the normal way. **Your excess** will be applied once per **period of cover** in respect of the well child benefit.

MAKING A CLAIM FOR COMPASSIONATE HOME TRAVEL

If **you** need to submit a **claim** for compassionate home travel **you** will need to complete our Compassionate Home Travel claim form and submit this to **us** with the following documents:

- A certified true copy of **your** relative's death certificate,
- **Your** travel documents which must state the cost of **your** tickets.

IMPORTANT POINTS TO REMEMBER WHEN SUBMITTING YOUR CLAIM

Your claim form must be fully and accurately completed and signed. **We** will not settle **your claim** if Section C has not been fully completed and signed by **your medical doctor** (or **dentist**).

We will not settle **your claim** unless **we** have the original invoices for the **treatment** **you** have received.

We will not pay **claims** which are received by **us** more than six months after the date of **treatment**, unless it was not reasonably possible for **you** to submit the **claim** within six months.

You must provide any information or proof **we** may reasonably require to support **your claim**. For example **we** may ask **you** for a medical report. If **we** do, **you** will have to provide the medical report at **your** own expense. **You** must, if requested to do so by **us**, provide **your** consent for **us** to obtain medical reports and medical records from any **medical doctor** or **medical practitioner** who has ever treated **you** or any **hospital** or clinic that **you** have ever been treated in. If **you** do not provide **your** consent, or any other information or proof **we** may reasonably require to support **your claim**, **we** will not pay **your claim**.

We do not pay **doctor's** fees for completing **your claim** form.

If after **you** have sent **us your claim** form **you** incur more invoices relating to the same illness or injury, send these to **us** quoting **your** certificate number and advising **us** that they relate to an on-going **claim**.

If **your treatment** continues for more than six months **we** reserve the right to ask **you** to submit a new **claim** form or an up-to-date medical report at **your** own expense.

When **we** are assessing the amount of benefit to which **you** are entitled, the amount **we** pay will not exceed the cover provided by the **plan you** have bought as stated on **your certificate of insurance**.

We have the right to appoint and pay for an independent **medical doctor** or **medical practitioner** to medically examine **you** and/or perform clinical tests and advise **us** on the medical issues relating to any **claim**. If **you** do not agree to have an independent examination or any clinical tests **we** request **we** will not pay **your claim**.

IMPORTANT REQUIREMENT IF YOU ARE ADMITTED TO HOSPITAL

If **you** are admitted to **hospital we** will require a fully completed Notification of Admission form before or as soon as reasonably possible after **you** are admitted to **hospital**. The Notification of Admission form must be completed by the **medical doctor** in charge of **your treatment** and must contain an exact diagnosis, details about the **treatment you** have received so far, what **treatment you** are going to have in the future and the date **you** are expected to leave **hospital**.

SETTLING YOUR CLAIM

After **you** have received **your treatment**, and upon receipt of **your claim**, **we** will send **you** an acknowledgement by email. Provided **we** have a fully completed **claim** form with all the information **we** require, and the original bills for the **treatment you** have received, **we** will settle **your claim** without any unnecessary delay.

All documents submitted in relation to **your claim** will become **our** property immediately upon settlement of **your claim** and the original documents cannot be returned.

Our preferred method of settlement is by bank transfer direct to **your** bank account, or, if **we** are paying the **hospital** direct, direct to the **hospital's** bank account. Alternatively **we** can issue a foreign currency draft, (provided **our** bankers are able to issue a draft in the currency **you** require), or a sterling, US dollar or euro cheque. **We** can also make payment in **your plan** currency to **your** visa card.

If **you** have an **excess** or **co-insurance** and **you** ask **us** to settle the **hospital's** or **doctor's** bills directly, **we** will deduct the **excess** or **co-insurance** amount and **you** will be responsible for paying the **excess** or **co-insurance** amount to the **hospital** or **doctor yourself**.

EXCHANGE RATES

We will settle **your claim** in the currency of **your plan** unless **we** are specifically requested to do otherwise. If **we** have to make a conversion from one currency to another, **we** will use the historical exchange rate, as provided by oanda.com, to four decimal places, for the day on which **you** have **your treatment**.

If **you** submit a bill for **treatment** received over a period of more than one day, to calculate the exchange rate **we** apply to that bill **we** will calculate the average exchange rate from the historical exchange rates applying on each day from the start of the **treatment** until the last date of **treatment**.

For example, **you** submit a bill which is for **treatment** which starts on 1st March and continues until 5th March. **We** will take the historical exchange rates on 1st March, 2nd March, 3rd March, 4th March and 5th March, and work out the average rate for that **treatment** period.

The exchange rate will be calculated in this way in respect of each separate bill **you** submit.

However, when **we** have placed a Guarantee of Payment, the exchange rate **we** use will be the one applicable on the date **we**, or the **Assistance Service**, issue the guarantee.

We are not responsible for any loss **you** may incur due to fluctuations in exchange rates, or for any bank charges **you** may suffer when **you** cash a foreign currency draft, a cheque or when **you** receive a bank transfer from **us**. **We** are not responsible for any loss incurred due to fluctuations in exchange rates, or for any bank charges incurred by a **hospital**, **medical doctor**, **medical practitioner** or any other medical service provider when they cash a foreign currency draft, a cheque or receive a bank transfer from **us**.

IF YOU ARE MAKING A CLAIM FOR AN ACCIDENT

If **you** are making a **claim** for injuries incurred as the result of an **accident you** must submit to **us** all relevant documentation including the police report, the ambulance report and any other report or documentation that would have been completed at the time, before **we** will settle **your claim**.

CLAIMS FOR AN 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 outlay 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** are able to recover the cost of any **treatment** for which **we** have paid, **you** must repay that amount (plus any interest) to **us**. If such repayment is not made **we** have the right to recover the expenses from **you**.

IF YOU ARE COVERED BY ANOTHER INSURANCE PLAN

If **you** have any other insurance cover for the cost of the **treatment** or benefit **you** have claimed from **us you** must tell **us** in writing as soon as possible or tell **us** on **your claim** form. If **you** do have other insurance cover, **we** will only pay **our** share of the cost of the **treatment**.

OUR RIGHT TO CANCEL YOUR PLAN IF WE HAVE BEEN MISLED

We can cancel **your** Global Health **plan** if **you** have misled **us** or been in breach of this **agreement**, given **us** incorrect, incomplete or misleading information, withheld any information, failed to provide any reasonable information which **we** have asked for, conspired with a third party to obtain benefit from this **plan**, or if **you** submit a **claim** which is in any respect fraudulent or unfounded. In any of these circumstances **we** have the right to cancel **your** cover from **your date of entry** and recover from **you** any benefit **we** have paid in relation to any **claim**. **We** also have the right to retain any **premium you** have paid to **us**.

5. IF YOU NEED TO BE EVACUATED FOR EMERGENCY TREATMENT

We will only pay for **your** evacuation costs if **you** have a **life-threatening condition** that is covered by **your plan** which requires immediate **in-patient treatment** that is not adequately available locally. The **Assistance Service** retains the right to decide whether **your** medical condition is **life-threatening**, whether the **treatment** available locally is adequate, where **you** are evacuated to, and the means and method of the evacuation.

CONTACTING THE ASSISTANCE SERVICE

It is a condition of this **agreement** that **you** contact the **Assistance Service** in a medical emergency.

If the **Assistance Service** agrees that **your** medical condition is **life-threatening**, is covered by **your plan**, cannot be treated adequately locally, and requires immediate **in-patient treatment**, the **Assistance Service** will make all the necessary arrangements to have **you** moved by air and/or surface transportation to the nearest **hospital** where appropriate medical **treatment** is available.

We will only pay for evacuation costs that have been authorised and arranged by the **Assistance Service**.

We will not pay for **your** evacuation costs if the reason for the evacuation is a medical condition that relates directly or indirectly to a **pre-existing condition**, a **related condition**, a condition which has been specifically excluded on **your certificate of insurance**, or any other medical condition or event specifically excluded in this **agreement**.

6. COSTS WE DON'T COVER

There are some costs and expenses **your** Global Health **plan** does not cover. **You** should also check **your certificate of insurance** for any **special terms** applying to **your** cover. Please read this section carefully as **we** will not pay for any expenses arising from:

ADDICTIVE CONDITIONS/DISORDERS AND ALCOHOL, DRUG AND SOLVENT ABUSE

We do not pay for any **treatment** or rehabilitation for, or arising from, or caused by any addictive condition or disorder, or misuse and/or abuse of drugs and/or alcohol, or substance or solvent abuse, even if it is related to prescribed drugs.

We do not pay for any **treatment** that is necessary as the direct or indirect result of **you** being under the influence of alcohol or drugs.

We do not pay for **treatment** of disease, illness or injuries sustained whilst **you** are under the influence of alcohol and/or drugs.

ALLERGY DESENSITISATION

We do not pay for allergy desensitisation or food neutralising injections.

ALTERNATIVE TREATMENTS AND THERAPIES

We do not pay for any alternative **treatments** and therapies such as pilates, yoga, bone-setting, hydrotherapy of any kind, aqua physiotherapy of any kind, kinesiology, colonic irrigation, IDD (Intervertebral Differential Dynamics), Integrated Manual Therapy, myotherapy, cranioelectrical stimulation, chelation therapy, naturotherapy, AIS Stretch Therapy, mesotherapy, craniosacral therapy, Ayurvedic medicine, biokinetic exercise technique (BET), Body Talk, Tecar therapy, Acupressure, magnet therapy or microcurrent therapy.

AUTOPSIES

We do not pay for autopsies.

BANK CHARGES AND ADMINISTRATION FEES

We do not pay for any bank charges **you** incur as a result of **us** transferring money to **your** account.

We do not pay administration fees charged by **hospitals**, **doctors**, or other providers of medical services.

BIRTH CONTROL, SEXUAL PROBLEMS AND SEX CHANGES

We do not pay for any **treatment** directly or indirectly arising from or connected with male and female contraception, sterilisation, sex changes, and the **treatment** of sexual problems (including impotence and decreased libido).

BIRTH DEFECTS, CONGENITAL CONDITIONS AND HEREDITARY CONDITIONS

We do not pay for any **treatment** for, or arising from birth defects, **congenital conditions** or hereditary conditions.

Congenital conditions are 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 child birth. However, **we** will pay for necessary **treatment** of birth defects or **congenital conditions** received by a newborn child or children born to a mother who has been insured by the Silver, Gold or Platinum **plan** for a continuous period of 12 months at the time of the birth. Cover is restricted to **treatment** received during the first 28 days of life and is limited to the amount stated in the **Table of Benefits** regardless of the number of children born.

CHRONIC CONDITIONS

If **you** are insured under the Bronze **plan** **you** do not have cover for the cost of **treatment** which maintains or controls the stability of a **chronic condition**. However, **your plan** does provide cover for **in-patient**, **day-patient** or **post hospital treatment** of an **acute** exacerbation of a **chronic condition**, provided it is not a **pre-existing condition**, or **related condition**, or a condition that is specifically excluded on **your certificate of insurance**.

If **you** are insured under the Silver **plan**, Gold **plan** or Platinum **plan** **we** will pay for consultations, tests and prescribed medication required to monitor and maintain the stability of a **chronic condition** up to the limits shown in the **table of benefits** for **your plan**.

If **you** have more than one **chronic condition**, the annual limit per **period of cover** applies to all **claims** for **chronic conditions**, and not to each **chronic condition**. For example, if **you** have a dollar Silver **plan** and **you** develop diabetes and asthma, the total **you** can **claim** in respect of both conditions during **your period of cover** is a maximum amount of \$10,000.

If **you** are insured under the Silver **plan**, Gold **plan** or Platinum **plan**, **your plan** also provides cover for **treatment** of an **acute** exacerbation of a **chronic condition**, provided it is not a **pre-existing condition**, or **related condition**, or a condition that is specifically excluded on **your certificate of insurance**. Cover is only provided in accordance with the benefits listed in the **table of benefits** and up to the annual limit specified for your plan type.

CIRCUMCISION

We do not pay for circumcision unless it is required as **treatment** for an **acute condition** covered by **your plan**.

CONTAMINATION

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

CONVALESCENCE AND HEALTH SPAS

We do not pay for **hospital** accommodation if the reason **you** are hospitalised is for the purpose of convalescence or supervision. **We** do not pay for relaxation or rest **treatments**, or **treatments** in nature clinics, health spas and nursing homes.

COSMETIC SURGERY AND TREATMENT

We do not pay for any **treatment** arising from or related to cosmetic, reconstructive or remedial surgery, the removal of fat or surplus tissue from any part of the body, breast enlargement or reduction, or any other **treatment** or procedure to change the shape or appearance of any part of **your** body whether or not it is needed for psychological or medical reasons.

However **we** will pay for a surgical operation to restore **your** appearance after an **accident**, or after surgery for breast cancer, provided the **accident** and/or breast cancer surgery occurred after **your date of entry** and provided the original **treatment** for the **accident** or breast cancer surgery was paid for by **us**, and provided the surgery takes place within two years of the **accident** or the original breast cancer surgery.

We do not pay for sclerotherapy for spider veins, surgical and non-surgical **treatment** of superficial varicose veins.

We do not pay for botulinum toxin, dermal fillers, or the **treatment** of vitiligo or any skin pigmentation disorder.

CRIMINAL ACTIVITY

We do not pay for any **treatment** arising from or related to injuries sustained whilst engaged in a criminal, illegal or unlawful act.

DENTAL TREATMENT

We do not pay for dental, gum or oral consultations or **treatment** of any kind other than those **treatments** specified in the **Table of Benefits** relating to **your plan**.

DEVELOPMENTAL PROBLEMS, LEARNING DIFFICULTIES, SPEECH DISORDERS AND BEHAVIOURAL PROBLEMS

We do not pay for the **treatment** of or related to developmental delay, learning difficulties, dyslexia, speech disorders, behavioural problems, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and physical development problems of any kind. **We** do not pay for any consultations or tests required to diagnose any of these conditions.

DIETICIAN

We do not pay for **treatment** and advice by a dietician.

EATING DISORDERS

We do not pay for **treatment** of or related to or caused by eating disorders of any kind. This includes the **treatment** of conditions such as anorexia nervosa, bulimia, bariatrics, and any **treatment** required for any condition caused as a result of these conditions.

EXCLUDED CONDITIONS AND COMPLICATIONS FROM EXCLUDED CONDITIONS

We do not pay for the **treatment** of any condition that is specifically excluded on **your certificate of insurance**.

We do not pay for any increased **treatment** costs **you** incur because of complications directly caused by a condition which is specifically excluded under the terms of this **agreement**, or which has been specifically excluded on **your certificate of insurance**.

We do not pay for the **treatment** of any condition arising as a consequence of any **treatment** **you** receive for a condition which is specifically excluded under the terms of this **agreement** or which has been specifically excluded on **your certificate of insurance**.

EXPERIMENTAL DRUGS AND TREATMENTS

We do not pay for experimental **treatments** and/or drugs. By experimental **treatment** **we** mean **treatment** which is not consistent with UK medical practice and guidelines regarding its type, frequency and duration. The UK guidelines used will be those published by the National Institute for Health and Clinical Excellence in the UK.

EYESIGHT

We do not pay for **treatment** to correct **your** eyesight, or for spectacles, and other visual aids. We do not pay for **treatment** of strabismus (squint). We do not pay for sight tests except as specified in the optical examination benefit available under the Platinum **plan**.

FAILURE TO FOLLOW MEDICAL ADVICE

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

FOETAL SURGERY

We do not pay for surgery undertaken on a child whilst it is in its mother's womb.

FOOT CARE

We do not pay for podiatry, chiropody, orthotics and gait scans.

GENETIC TESTING AND/OR GENETIC ENGINEERING

We do not pay for genetic testing and/or genetic engineering.

HEALTH HYDROS AND NATURE CURE CLINICS

We do not pay for **treatment** received in health hydros, nature cure clinics or similar establishments or private beds registered as nursing homes attached to such establishments or a **hospital** where the **hospital** has effectively become **your** home or permanent abode.

HEARING

We do not pay for **treatment** for or arising from deafness caused by a congenital abnormality, maturing or ageing. We do not pay for hearing tests and hearing aids.

HIV/AIDS

We do not pay for **treatment** or testing for, or arising from, or related to Human Immunodeficiency Virus (HIV), or Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC), and/or similar infections or illnesses and injuries, including any condition which is related to, or results from HIV or AIDS, no matter how caused.

However, once **you** have been insured by the same **plan** type for a continuous period of 24 months, **we** will pay for **treatment** arising from or related to HIV/AIDS/ARC up to the annual benefit limit specified in the **Table of Benefits** relating to **your plan** for a maximum period of 5 years, provided the HIV was first contracted after **your date of entry** to the **plan**. We do not pay for routine HIV testing.

HOSPITAL TREATMENT COSTS THAT HAVE NOT BEEN AUTHORISED

We do not pay for **in-patient** or **day-patient hospital treatment** costs which have not been authorised in advance by **us** or by the **Assistance Service**.

HYPERBARIC OXYGEN THERAPY

We do not pay for hyperbaric oxygen therapy, unless it is used as **treatment** for decompression sickness.

INFERTILITY, IVF AND ASSISTED REPRODUCTION

We do not pay for testing or diagnosis related to infertility except as specified in the infertility investigations benefit available under the Platinum **plan**. We do not pay for infertility **treatment**, assisted reproduction (e.g. IVF **treatment**), including establishing pregnancy. There is no cover for **complications of pregnancy** arising from a pregnancy established through assisted reproduction until after the 12-week scan, irrespective of how long **you** have been covered by the **plan**.

There is no cover in respect of **treatment** of any newborn child (within the first 28 days of life), born following assisted reproduction **treatment** (e.g., IVF), in the event of any multiple birth and/or in the event of any birth occurring within 36 weeks of conception.

KIDNEY DIALYSIS

We do not pay for regular or long-term kidney dialysis in the case of **chronic** kidney failure, although **we** will pay for 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.

MENOPAUSE, PERI-MENOPAUSE, ANDROPAUSE, AGEING, PUBERTY, PRE-MENSTRUAL TENSION SYNDROME, HRT & BONE DENSITOMETRY

We do not pay for **treatment** to relieve symptoms associated with any bodily change such as the menopause, peri-menopause, andropause, puberty, teething, growing, ageing and pre-menstrual tension syndrome which is not due to any underlying disease, illness or injury. We do not pay for hormone replacement therapy (HRT) and **we** do not pay for bone densitometry other than as specified under the Well-being benefit.

NASAL SEPTUM DEVIATION

We do not pay for the **treatment** of nasal septum deviation. In the event that **treatment** of nasal septum deviation takes place concurrently with **treatment** of other conditions, **we** will only pay for a proportion of the **treatment** on a pro-rata basis, e.g. if **you** receive **treatment** for nasal septum

deviation, plus one covered condition, **we** will pay half of the **reasonable and customary** cost of the **treatment**. If **you** receive **treatment** for nasal septum deviation, plus two covered conditions, **we** will pay two thirds of the **reasonable and customary** cost of the **treatment**.

ORGAN TRANSPLANT, STEM CELL HARVESTING OR TISSUE TRANSPLANTS

We do not pay for any:

- Organ transplant, (other than for kidney, liver, heart, lung, or heart and lung transplants as specified in the **Table of Benefits**),
 - Stem cell harvesting,
 - Tissue transplants including those from the patient's own body (other than bone marrow transplants),
- or any **treatment** undertaken in anticipation of, prior to, or following such transplants.

PALLIATIVE CARE

Other than any benefit payable under the **Hospice** care benefit specified in the **Table of Benefits** relating to **your plan** **we** do not pay for palliative **treatment** of a medical condition.

PRE-EXISTING CONDITIONS

We do not pay for the **treatment** of any medical condition or **related medical condition** which existed, or which ever required **treatment**, medication or advice from a **medical doctor** or **medical practitioner** or **specialist**, or which was diagnosed, or for which the symptoms first appeared, prior to **your date of entry** to the Global Health **plan**, or any medical condition that **you** knew about, or would reasonably have known existed, whether or not **you** had consulted a **medical doctor**, or **medical practitioner** at **your date of entry** to the Global Health **plan**.

However, if **you** have given **us** full and accurate details of a **pre-existing condition** on **your application form** and **we** have not specifically excluded that condition on **your certificate of insurance** **we** will pay for the **treatment** of that **pre-existing condition** if it recurs.

PREGNANCY, CHILDBIRTH AND TERMINATION OF PREGNANCY

We do not pay for **treatment** relating to pregnancy and childbirth or any condition arising from pregnancy and childbirth, including termination of pregnancy for whatever reason. **We** do not pay for routine pregnancy testing.

However, **we** will pay for **in-patient** or **day-patient hospital treatment** received for **complications of pregnancy** (as defined in this **agreement**) after **you** have been insured by the Global Health **plan** for a continuous period of 12 months. Cover for **complications of pregnancy** is restricted to **in-patient** and **day-patient treatment** received for a medical condition which arises during the antenatal or postnatal stages of pregnancy. The amount **we** pay is limited to the amount shown in the **Table of Benefits** of **your** Global Health **plan**. There is no cover for **treatment** received due to **complications of pregnancy** arising during **your** first twelve months of cover. There is no cover for **treatment** received due to **complications of pregnancy** if **you** act as a surrogate or have anyone else acting as a surrogate for **you**.

No cover is provided under the **Complications of Pregnancy** benefit for childbirth including an emergency caesarean section. There is no cover for **complications of pregnancy** arising from a pregnancy established through assisted reproduction until after the 12-week scan, irrespective of how long **you** have been covered by the **plan**.

If **you** are insured by the Gold or Platinum **plan** **we** will pay for the cost of surgeon, anaesthetist and theatre fees for childbirth which necessitates an emergency surgical procedure and for any additional accommodation charges incurred as the result of the surgical procedure up to the limit shown in the **Table of Benefits** of **your** Global Health **plan**. Any charges incurred as the result of normal childbirth will be paid from the routine maternity benefit.

If **you** are insured by the Gold **plan** **we** will pay 80% of the cost of routine maternity care and **out-patient complications of pregnancy** once **you** have been insured by the Gold **plan** for a continuous period of 12 months. Routine maternity care means pre-natal and post-natal **treatments** and examinations and natural childbirth or childbirth by elective caesarean section, subject to the benefit limits stated in the **Table of Benefits** relating to the Gold **plan**.

If **you** are insured by the Platinum **plan** **we** will pay the cost of routine maternity care and **out-patient complications of pregnancy** once **you** have been insured by the Platinum **plan** for a continuous period of 12 months. Routine maternity care means pre-natal and post-natal **treatments** and examinations and natural childbirth or childbirth by elective caesarean section, subject to the benefit limits stated in the **Table of Benefits** relating to the Platinum **plan**.

There is no cover for routine maternity care and childbirth expenses if **you** act as a surrogate or have anyone else acting as a surrogate for **you**. There is no cover for ante-natal classes or doulas.

PROFESSIONAL SPORTS AND MOTORISED RACING AS AN AMATEUR OR A PROFESSIONAL

We do not pay for injury or illness arising from participation in any kind of professional sport or professional racing of any kind. By professional **we** mean sport where **you** are being paid to participate. **We** do not pay for injury or illness arising from participation in any kind of racing, (whether amateur or professional), which involves the use of a motorised vehicle.

PSYCHIATRIC CONDITIONS

There is no cover for **treatment** of any psychiatric condition, or **treatment** of any condition caused by or relating to any psychiatric condition until **you** have been insured by the Global Health **plan** for a continuous period of 24 months.

Once **you** have been insured by the Global Health **plan** for a continuous period of 24 months, **we** will pay for **treatment** of psychiatric conditions and **treatment** of conditions caused by or relating to any psychiatric conditions, subject to the life-time limit applicable to **your plan**. However, the following exclusions apply to **your** cover permanently, and not just during the first 24 months:

- **We** do not pay for **treatment** of any **pre-existing condition** or **related condition**.
- **We** do not pay for **treatment** of any psychiatric condition or **treatment** of any condition caused by or relating to any psychiatric condition that has not been pre-authorised by **us**.
- **We** do not pay for any **treatment** or rehabilitation required as a result of or in connection with addiction to or abuse of alcohol, drugs solvents or tobacco.
- **We** do not pay for any **treatment** or rehabilitation required as a result of or in connection with addiction to gambling.

- **We** do not pay for any **treatment** or rehabilitation required as a result of or in connection with eating disorders of any kind, including but not limited to anorexia nervosa, bulimia, bariatrics and morbid obesity, and the **treatment** of any resulting physical conditions.
- **We** do not pay for **treatment** of any psycho-geriatric conditions or for any type of dementia.
- **We** do not pay for any **treatment** required as a result of or in connection with sexual dysfunction.
- **We** do not pay for drugs prescribed for **out-patient** psychiatric **treatment**.
- **We** do not pay for hypnotherapy.
- **We** do not pay for marriage counselling.

ROUTINE AND PERIODIC HEALTH CHECKS AND MOLE MAPPING

Apart from any cover available to **you** under the well-being benefit, the well-child benefit, the vaccinations benefit, the optical examination benefit and the **chronic conditions** benefit **we** do not pay for health screening such as routine health checks, child development and growth checks, periodic health checks required following **treatment** for a specific illness or injury, routine gynaecological tests, paediatric vaccinations, vaccinations or preventive **treatment** of any kind including mole mapping and solar scans.

However, if **you** have received **treatment** for an injury or illness (other than cancer) which has been covered by **your plan** and for which it is **medically necessary** that **you** have periodic health checks, **we** will pay for these periodic health checks provided they occur within one year from the end of **your** original **treatment**, (or within 90 days from the date on which **you** were discharged from **hospital** if **you** are covered by the Elite Bronze **plan**).

SCALP AND/OR HAIR TREATMENTS, WIGS AND ALOPECIA

We do not pay for any **treatment** of the scalp and/or hair or for wigs, or for the **treatment** of alopecia.

SEARCH AND/OR RESCUE

We do not pay for search and/or rescue operations including, but not limited to, mountain rescue or rescue from ski slopes or pistes. **We** do not pay for 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

We do not pay for second or subsequent medical opinions from a **medical doctor**, **medical practitioner** or **specialist** for the same condition unless it has been authorised by **us** in advance. **We** do not pay for any duplication of tests.

SELF-INFLICTED INJURIES AND/OR SUICIDE

We do not pay for **treatment** of self-inflicted injuries or **treatment** of any injury or illness directly or indirectly caused by self-inflicted injuries.

We do not pay for repatriation, burial or cremation of mortal remains if **you** commit suicide.

SEXUALLY TRANSMITTED DISEASES

We do not pay for the testing or **treatment** of sexually transmitted diseases such as but not limited to genital warts, syphilis, gonorrhoea, genital herpes, chlamydia, pubic lice or trichomoniasis.

SLEEP DISORDERS

We do not pay for **diagnostic tests** for, or **treatment** of, insomnia, sleep apnoea, snoring, or any other sleep-related problem. **We** do not cover diagnosis and **treatment** for obstructive sleep apnoea due to morbid obesity and obesity-hypoventilation syndrome.

SURGICAL OR MEDICAL APPLIANCES OR EQUIPMENT

We do not pay for supplying, fitting or hiring physical aids and devices (for example crutches, splints, walking sticks and wheelchairs) except as specified under the Medical Aids and Devices benefit. **We** do not pay for any prostheses, or the preparation for, or the fitting of artificial limbs except as specified under the Prostheses benefit.

TOURETTE'S SYNDROME

We do not pay for the testing or **treatment** of Tourette's Syndrome.

TRAVEL COSTS

We do not pay for any travel costs including airfares and hotel accommodation except as specified in the Emergency evacuation benefit in the **Table of Benefits** relating to **your plan**.

TREATMENT BY A FAMILY MEMBER

We do not pay for **treatment** provided by and/or under the control of and/or on referral from any family member such as, but not limited to, a spouse, partner, parent, brother, sister, child, grand-parent, grand-child, uncle or aunt.

VITAMINS, DIETARY SUPPLEMENTS AND NATURAL SUBSTANCES

We do not pay for vitamins, dietary supplements and substances which are available naturally and that can be purchased without prescription including, but not limited to, vitamins, minerals and organic substances.

WAR AND TERRORISM

We do not pay for **treatment** of any condition or **claim** arising directly or indirectly from or as a consequence of 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, unless **you** are an innocent bystander. However, no cover for war and terrorism will be provided if **you** remain in, or travel to, a country, or a region within a country, that the British Foreign and Commonwealth Office has advised its citizens to leave, and/or **you** travel to a country which is specifically excluded on **your certificate of insurance**. It is **your** responsibility to keep abreast of the British Foreign and Commonwealth Office advice.

Notwithstanding the above **we** do not pay for the **treatment** of any condition or **claim** arising directly or indirectly from chemical or biological or nuclear contamination, however caused, including expense in any way caused by or contributed to by acts of war and/or terrorism even if **you** are an innocent bystander.

WEIGHT-RELATED CONDITIONS

We do not cover weight monitoring or weight disorders. **We** do not cover **treatment** by or consultations with dieticians. **We** do not cover the diagnosis and **treatment** of morbid obesity. **We** do not cover procedures such as bariatric surgery, gastric bypass, sleeve gastrectomy, lap-banding and Roux-en-Y gastric bypass, or any pre-emptive cholecystectomy (gall bladder removal), and **we** do not cover **treatment** required as the consequence of any such procedure having been carried out. **We** do not cover contouring surgery and/or removal of excess skin after excessive weight loss or the consequences of any such **treatment**. **We** do not cover weight loss programmes, or **treatment** at a weight loss spa.

WILFUL EXPOSURE TO NEEDLESS DANGER

We do not pay for **treatment** of any conditions arising directly or indirectly from **your** gross negligence and/or **your** wilful exposure to needless danger except in an attempt to save a human life.

7. POLICY ADMINISTRATION

GLOBAL HEALTH PREMIUMS

Your employer is responsible for paying to **us** your Global Health **premiums**, and **premiums** for **your** dependants.

We must be in receipt of **your premium** before **we** will commence **your** cover.

Your Global Health cover will only remain in force whilst **you** are employed by **your employer** and during the period for which **we** have received payment of the appropriate **premium** from **your employer**. **We** will not pay for any **treatment** expenses incurred after **your** cover has ended.

UNPAID OR LATE PREMIUMS

We will automatically cancel **your** cover if **your employer** fails to pay **your premium** on or before the date it is due. However, **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 its **due date**. If **you** incur medical expenses during this 30 day period, **we** will not settle **your claim** until **we** have received **your** outstanding **premium**.

If a **premium** is outstanding for more than 30 days **your employer** will have to apply for a new Global Health **plan** and if **you** are accepted for cover, the **pre-existing condition** exclusion will apply from **your date of entry** to your new **plan**. **We** may accept **your** new application with or without **special terms** or **we** may refuse to accept **your** application at **our** sole and complete discretion and without being required to give any reason for **our** decision.

ADDING A NEW ELIGIBLE DEPENDANT

If **you** wish to add a new spouse or partner or child to **your plan**, **you** must complete a new **application form**. **We** will not commence cover for a new dependant until **we** have accepted **your** application for that new dependant, and until **we** have received payment of their **premium** from **your employer**. **We** will calculate their **premium** based on their age at their **date of entry**.

ADDING NEWBORNS

If employee's dependent children are eligible for cover under your **employer's** policy, **you** can add a newborn child of a mother insured under the **plan**, at the same level of cover as the mother, without any medical underwriting, provided **you** do so within the first 28 days of life. **You** must complete a new **application form** and neonatal questionnaire in respect of all newborn children, and submit these to **us** along with the newborn's discharge summary. Birth defects, **congenital conditions** and hereditary conditions are excluded from cover. However, other **pre-existing conditions** will not be excluded, provided **your** fully completed application form, neonatal questionnaire, discharge summary and the additional **premium** that **we** will charge to your **employer** are all received by **us** within 28 days of birth.

If the application is for the newborn to be covered by a **plan** type with wider benefits than the mother, or with a lower **excess** than the mother, any increase in cover or reduction in the **excess** may be subject to **special terms** or **we** may restrict the cover to the same level as the mother, at **our** sole and complete discretion and without being required to give any reason for our decision.

If the application form, neonatal questionnaire, newborn's discharge summary and payment of the additional premium due from your employer are not all received within 28 days of birth, we may accept the new application with or without special terms, or we may refuse to accept the application at our sole and complete discretion and without being required to give any reason for **our** decision.

(NB: If the mother of the newborn child has been insured under the Silver, Gold or Platinum plan for a minimum period of 12 months the newborn is automatically covered for hospital **in-patient** and **day-patient treatment**, including **in-patient** and **day-patient treatment** of **congenital conditions**, for the first 28 days of life up to the amount specified in the **Table of Benefits**).

CHANGING YOUR ADDRESS, COUNTRY OF RESIDENCE OR EMAIL ADDRESS

You must tell **us** if you change your address and if you change **your country of residence**. A change of address form is provided on our website at www.william-russell.com/webworks/office. **Your country of residence** is the country in which you are habitually resident.

You must tell **us** if you change **your** email address.

IN THE EVENT OF THE DEATH OF AN INSURED PERSON

Please inform **us** as soon as possible in the event of the death of an **insured person**.

WHEN YOUR EMPLOYMENT TERMINATES

Your cover, and cover for **your eligible dependants**, will cease automatically from the date on which **your** employment with **your employer** is terminated.

APPLICABLE LAW

The law of Dubai shall apply.

COMPLAINTS PROCEDURE

We want to provide **you** with a first class standard of service at all times. If **you** feel that **our** service has been poor or **you** feel that any decision **we** make about a **claim** is unfair and not in accordance with the terms of this **agreement**, please let **us** know by contacting:

The Executive Manager (Middle East), Global Plans Team, Dubai Insurance Company psc, PO Box 3027, Dubai, UAE.

Tel: + 971 4 2697706 Fax: + 971 4 2691304

All complaints will be acknowledged by telephone, email or letter by the end of the following working day.

All complaints will receive a full and detailed written response within two weeks of issuing **our** acknowledgement.

8. DEFINITIONS

A clear explanation of certain terms used within this agreement

This section explains what **we** mean by certain words and phrases in this **agreement**. Words written in bold both here and in this **agreement** are particularly important as they have a specific meaning.

Accident means a sudden, unexpected, specific event which occurs at an identifiable time and place.

Acute condition means 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.

Africa and the Indian Subcontinent means Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo (Brazzaville), Djibouti, Egypt, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mayotte, Morocco, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, West Sahara, Zaire (Democratic Republic of Congo), Zambia, Zimbabwe, Ascension Island, St Helena, Equatorial Guinea and the Indian subcontinent countries of Afghanistan, Bangladesh, Bhutan, Myanmar, British Indian Ocean, Comoros, Heard Island, India, Maldives, Mauritius, Nepal, Pakistan, Seychelles and Sri Lanka.

Agreement means the contents of this booklet read in conjunction with the **Master Certificate of Insurance** issued to **your employer**, **your** completed and signed **application form** and **your certificate of insurance**. Together these items make up **your** Global Health **plan** contract with **us**.

Application form means the **application form** **you** have completed and signed on behalf of **yourself** and on behalf of any of **your** dependants for whom cover is requested.

Area of cover means the territorial limits of **your plan**.

Assistance Service means the emergency assistance company contracted by **us** to provide assistance services to Global Health **plan** members at the time of **your claim**.

Certificate of insurance means the confirmation of insurance cover issued by **us**. **Your certificate of insurance** confirms the **plan** **you** have bought, its currency, **your area of cover**, **your period of cover**, **your date of entry**, **your renewal date**, the **excess** amount, any **special terms** relating to **your** cover, **your country of residence**, **your home country**, and a **schedule of insured persons**. The **schedule of insured persons** lists the persons insured by **us** under **your agreement** with **us**. If there are any changes to the details on **your certificate of insurance** **we** will issue **you** with a new **certificate of insurance** confirming the changes.

Chronic Condition means a disease, illness or injury which has at least one of the following characteristics;

1 It continues indefinitely and has no known cure, **2** It comes back or is likely to come back, **3** It is permanent, **4** **You** need to be rehabilitated or specially trained to cope with it, **5** It needs long-term monitoring, consultations, check ups, examinations or tests.

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

Co-insurance means the contribution that **you** must make towards the eligible costs of **your claim**.

Complications of pregnancy means **treatment** received for a medical condition which arises during the antenatal or postnatal stages of pregnancy after **you** have been covered by the Global Health **plan** for a continuous period of 12 months. There is no cover for **complications of pregnancy** received within the first 12 months of **your plan**. There is no cover for **complications of pregnancy** arising from a pregnancy established through assisted reproduction until after the 12-week scan, irrespective of how long **you** have been covered by the **plan**.

Congenital conditions means any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not, or any deformity arising during the antenatal stages of pregnancy.

Country of residence means the country in which **you** are habitually resident.

Date of entry means the date on which cover for **you** and each of **your** dependants first commenced.

Day-patient. **You** are a **day-patient** when, for medical reasons, **you** have to go into a **hospital** or **day-patient** unit because **you** need a period of clinically-supervised recovery but it is not **medically necessary** for **you** to stay overnight.

Dentist means a person legally carrying out this profession in the country in which he or she is located.

Diagnostic tests means investigations, such as x-rays or blood tests, to find or to help find the cause of **your** symptoms.

Eligible dependants are your spouse or partner with whom you live, (provided the spouse or partner is under 65 years of age at **their date of entry**), and your unmarried children provided the unmarried children are aged less than 18 years old, or less than 25 years old if in continuous full-time education. **We** reserve the right to request and receive proof of a dependant child being in full-time education.

Emergency treatment means essential **treatment**, covered by **your plan**, and required if **you** suffer an **accident** or a sudden unforeseen illness **you** have never suffered from before.

Employer means the **policyholder** specified as **your employer** on **your certificate of insurance**.

Excess means the amount stated as the **excess** in **your certificate of insurance**, being the amount **you** must contribute towards each **claim**. If **your excess** is per annum, the **excess** stated on **your certificate of insurance** is the amount **you** must contribute towards the cost of **treatment** received within the same **period of cover**

Excluded country or area means the USA, Canada, the Caribbean countries and islands, and the **London area**.

Full refund means we will pay all **reasonable and customary treatment** charges subject to any annual and/or life-time limits that may apply.

Home country means **your** country of origin for which **you** hold a passport. If **you** hold more than one passport **your home country** will be the country **you** have declared on **your application form**. For the purposes of this **agreement** **your** spouse or partner and dependent children will be regarded as having the same **home country** as **you**.

Hospice means an **in-patient** facility that provides palliative care and attends to the needs of terminally ill patients.

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

In-patient. You are an **in-patient** if **you** receive **treatment** which, for medical reasons, means that **you** have to stay in **hospital** overnight.

Insured person means any person specified in the **certificate of insurance** as the **insured person**.

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

Life-threatening condition means 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**.

London area means any address in the United Kingdom with a London postcode.

Medical doctor means a person who has the primary degrees in the practice of medicine and surgery following attendance at a recognised medical school and who is licensed to practise medicine by the relevant licensing authority where the **treatment** is given. By recognised medical school **we** mean a medical school which is listed in the current World Directory of Medical Schools published by the World Health Organisation.

Medically necessary means **treatment** that is medically appropriate and necessary to treat a condition that is covered under the terms and conditions of this **agreement**, and which is consistent with UK medical practice and guidelines regarding its type, frequency and duration. The UK guidelines used for the purpose will be those published by the National Institute for Health and Clinical Excellence in the UK.

Medical practitioner means 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, physiotherapy, osteopathy, or chiropractic **treatment**, and to whom **you** have been referred by a **medical doctor**.

Medical network provider means a **hospital, out-patient** clinic, **medical practitioner** or pharmacy who is part of the Neuron network of medical providers **you** are authorised to use. The Neuron network of medical providers **you** are authorised to use is as stated on **your certificate of insurance** and on **your** Neuron network card.

Out-patient. You are an **out-patient** when **you** receive **treatment** at a **hospital** consulting room, emergency room or **out-patient** clinic, when it is not **medically necessary** for **you** to be admitted as a **day-patient** or an **in-patient**.

Period of cover as stated on **your certificate of insurance** and cover will remain in force during this period subject to the terms and conditions of this **agreement**, and provided **we** receive **your premium(s)** from **your employer** on or before their **due date(s)**. If a **premium** is not received by **us** on or before its **due date**, **your period of cover** will end from the day before the unpaid **premium's due date**.

Plan means the Global Health Bronze **plan**, Silver **plan**, Gold **plan** or Platinum **plan**.

Policyholder means **your employer**, i.e. the company **you** are employed by and on whose payroll **you** appear.

Post-hospital treatment is **medically necessary** follow-up consultations, physiotherapy, **diagnostic tests** and/or **treatment** required on an **out-patient** basis following **in-patient** or **day-patient treatment** covered by **your plan** and received within the 90 day period following the date **you** are discharged from **hospital**.

Pre-existing conditions means any disease, illness or injury for which:

1. **You** have received medication, advice or **treatment**; or
2. **You** have experienced symptoms;

whether the condition has been diagnosed or not, at any time before the start of **your** cover.

Premium means the amount(s) **your employer** is required to pay to **us** either annually, semi-annually, quarterly or monthly for this insurance cover.

Premium due date, or **due date** means the date on which **your premium** falls due.

Reasonable and customary means the charge that would typically be made for **your treatment** by medical service providers in the country in which **you** receive **your treatment**. If the cost of **your treatment** is more than the charge that would typically be made by medical service providers, in the country in which **you** receive **your treatment**, **we** will only pay up to the amount which is typically charged in that country. In the event of a dispute, **we** will identify the amount typically charged for **your treatment** by medical service providers in the country in which **you** receive it, by obtaining three quotations and taking a mean average of these three quotations.

Recognised medical treatment means **treatment** that is medically appropriate and necessary to treat a condition that is covered under the terms and conditions of this **agreement**, and which is consistent with UK medical practice and guidelines regarding its type, frequency and duration. The UK guidelines used for the purpose will be those published by the National Institute for Health and Clinical Excellence in the UK.

Rehabilitation is **treatment** aimed at restoring **your** form and/or function to the state it was in immediately before suffering an **acute** illness or injury.

Rehabilitation hospital or unit means a 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 means any disease, illness or injury that is caused by a **pre-existing condition** or results from the same underlying cause as a **pre-existing condition**.

Renewal date is shown on **your certificate of insurance** and will normally be the anniversary of **your** original **date of entry** to the Global Health **plan**.

Restricted country or **restricted countries** means a country outside **Africa and the Indian Subcontinent**, and outside the USA, Canada, the Caribbean, and outside the **London area**.

Specialist means a surgeon, anaesthetist or physician who is legally qualified to practice medicine or surgery following attendance at a recognised medical school, and who is recognised by the relevant authorities in the country in which the **treatment** takes place as having a specialised qualification in the field of or expertise in, the **treatment** of the disease, illness or injury being treated. By recognised medical school **we** mean a medical school which is listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation.

Special terms mean any exclusions or conditions which **we** may apply to **your plan**. Any **special terms** relating to **your plan** will appear on **your certificate of insurance**.

Table of benefits. **Table of benefits** means the benefits set out in pages 8-15 of this booklet.

Temporary trip means a trip **you** take to the United States of America for business or pleasure of not more than 45 days duration if **you** have Area Two cover, or 90 days duration if **you** have Area Three cover. If **you** have Area Four cover, **temporary trip** means a trip **you** take outside **Africa and the Indian Subcontinent** for business or pleasure of not more than 90 days.

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

Us, we, our means Dubai Insurance Company psc, or Neuron LLC, on behalf of Dubai Insurance Company psc.

Well-being benefit medical report form is the medical examination report form which specifies the medical tests eligible for cover under the well-being benefit. This report form must be obtained from **us** before **you** have a medical examination for which **you** intend to **claim** under the well-being benefit.

You, your, yourself means any and all persons named in the schedule of **Insured Persons** on **your certificate of insurance**.

9. PRIVACY AND DATA PROTECTION STATEMENT

The confidentiality of **your** personal information is a matter that **we** take very seriously. **Your** personal data will be processed by **us** in accordance with UK and EU Data Protection laws, including the Data Protection Act (1988) and the EU Data Protection Directive 95/46/EC.

We will use **your** personal data solely for the purpose of processing **your** policy and claims. **Your** personal information may be passed to the **insurers** of **your plan**, to **your doctors** and other medical professionals involved with **your treatment**, to **our** emergency assistance companies and other agents, and to any regulatory body that may require **us** to disclose it. In the event of fraud or suspected fraud **we** reserve the right to pass **your** personal data to other parties, including but not limited to appropriate law enforcement agencies. **Your** personal information will not be disclosed to any other party unless **you** specifically authorise **us** to disclose it.

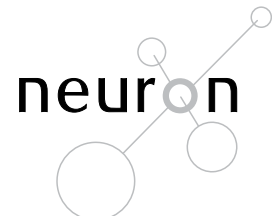


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