orient اورينت

Paid Up Capital: Dhs. 405,000,000

Registered under Federal Law No. (6) of 2007
Certificate No. 14 dated 29th December 1984
Commercial Registration 51814

رأس المال المدفوع: ٤٠٥،٠٠٠،٠٠٠ درهم
مسجلة طبقاً للقانون الإتحادي رقم (٦) لسنة ٢٠٠٧م
شهادة رقم ١٤ بتاريخ ١٩٨٤/١٢/٢٩م
رقم السجل التجاري ٥١٨١٤

REF: WK/MC/29708/2013 February 13, 2013

SOLTIUS MIDDLE EAST FZ LLC
U.A.E

Attn: - Dear Sir / Madam,

RE: - GROUP MEDICAL INSURANCE COVER
SOLTIUS MIDDLE EAST FZ LLC
POLICY NUMBER - # CPG/10/0/001283/2013

We thank you for having **renewed** the above Medical Insurance Scheme with us and have pleasure of enclosing the following documents:

- Policy document **# CPG/10/0/001283/2013**. This document has been prepared in accordance with the updated information submitted to us, however, for sake of good order we would ask you to check the document carefully to ensure that it meets with your requirement. Should there be any clarification or amendment that you may require, please do not hesitate to contact us immediately for rectification.

- Premium invoice, the payment mode is **QUARTERLY**

Please sign and return one copy of the Group Policy for our records

Finally we would like to thank you for having **renewed** this insurance with us and in turn, we would like to assure you of our best attention at all times.

Yours sincerely,

for **Wissam Khalifeh**
Assistant General Manager – Medical Dept.

Insurance Policy No: **CPG/10/0/001283/2013**

CAREPLUS MEDICAL INSURANCE

SOLTIUS MIDDLE EAST FZ LLC

GROUP HEALTH INSURANCE POLICY

Whereas the Employer (herein after called the **Policyholder**) has made to **Arab Orient Insurance Company** (herein after called the **Company**) a written proposal and declaration together with any information or particulars from time to time supplied to the **Company** by the **Policyholder** in accordance with Benefits Schedule shall be the basis of this contract and be considered as incorporated herein,

It is hereby agreed that in consideration of the payment of the first premium and on condition that the subsequent premiums are paid in accordance with the provisions of the **Policy**, the **Company** agrees to provide the insurance cover as described in the Benefits Schedule or in any Endorsements attached hereto, subject to the conditions and provisions stated hereto and/or endorsed and signed for and/or behalf of the **Company.**

Acceptance and use of the Access Card(s) automatically implies acceptance of all the terms, conditions, limitations and exclusions of this Policy.

Signed on behalf of the Parties on this **February 13th of 2013**

The Insurer | **The Policy Holder**

Insurance Policy No: **CPG/10/0/001283/2013** CAREPLUS MEDICAL INSURANCE

SECTION 1 – DEFINITIONS

DEFINITIONS

Accident: -

A sudden, unplanned and unexpected external event not under control of the Insured Person that results involuntarily in bodily injury occurring whilst the **Policy** is in force.

Acute: -

A **Medical Condition** which is brief, has a definite end point and which the **Company,** on **Advice** or **General Advice** determine responds to and can be cured by **Treatment.**

Advice: -

Any consultation from a **Medical Practitioner** or **Specialist** including the issue of any prescriptions or repeat prescriptions.

Appliances: -

Devices and equipment when used as an integral part of a medical procedure administered by a **Medical Practitioner** or **Specialist.**

Benefits: -

The insurance coverage provided by this **Policy** and any extensions or restrictions shown in the **Policy Schedule** or in any endorsements (if applicable).

Careplus Access Card: -

A Personalised card issued in the name of each **Insured person,** facilitating his/her access to the Healthcare services covered under this Insurance **Policy** and provided by the Network.

Chronic Chondition:-

An incurable disease requiring a long, continuous and regular treatment.

Insurance Policy No: **CPG/10/0/001283/2013** CAREPLUS MEDICAL INSURANCE

Co-insurance: -

The percentage of the total value of the incurred expenses for which the **Policyholder** is responsible.

Commencement Date: -

The date shown on the **Policy Schedule** on which cover under this **Policy** commences. For the purpose of this **Policy** the time of the start of cover will be 00:01am on the date shown on the **Policy Schedule.**

Congenital Anomaly: -

A condition existing at or from birth which is a significant deviation from the common form or normal and for the purposes of this **Policy** will include both visible and hidden structural body deviations as well as chromosomal abnormalities.

Country of Nationality: -

For the purpose of this **Policy** this will be the country for which the **Insured Person** holds a passport.

Country of Residence: -

The country in which Insured Members has **his/her** habitual residence (residing for a period of **not less** than six months per **Period of Cover**) at the time this **Policy** is first taken out or at each subsequent **Renewal Date.**

Day-Patient: -

Same day surgery, treatment or investigations not requiring an overnight stay at the Hospital but, nevertheless, necessitating specialized medical attention and care in a Hospital before, during and after the surgery, treatment or investigation, but do not medically necessitate an overnight stay in a Hospital.

Dental Practitioner: -

A person who is licensed by the relevant licensing authority to practice dentistry in the country where the dental **Treatment** is given.

Insurance Policy No: **CPG/10/0/001283/2013** CAREPLUS MEDICAL INSURANCE

Date of Entry: -

The date shown on the **Policy Schedule or Endorsement** on which an **Insured Person** was included under the **Policy.**

Drugs and Dressings:-

Drugs, medicines and dressings prescribed by a **Medical Practitioner** or **Specialist.**

Dependants: -

A spouse or adult partner and/ or unmarried children who are not more than 18 years old and residing with the **Policyholder,** or 23 years old if in full-time education or un-married at the date of joining or at any annual **Renewal Date.**

All **Dependants** must be named as **Insured Person's** in the **Policy Schedule.**

Emergency:-

A situation or condition placing the **Policyholder** in an immediate life-threatening situation.

Evacuation:-

Costs incurred in moving an **Insured Person** from the place of incident to the nearest appropriate medical facility, as determined by the attending **Medical Practitioner** or **Specialist** in conjunction with the Third Party Administrator.

Excess:-

The amount payable by an **Insured Person** in respect of expenses incurred before any **Benefits** are paid under the **Policy.**

Expatriate:-

Any persons living or working outside of the country for which they hold a passport for a period in **Excess** of 6 months per **Period of Cover.**

Free Access: -

The medical providers where **Insured Members** are able to obtain medical **Treatment** for valid **Medical Conditions** and where the expenses will be settled directly by the

Company. Insured Members are still responsible for any **Co-insurance** or **Excess** applicable to the **Policy** which must be settled directly to the medical providers at the time of **treatment.**

Please Note:- Where a **Insured Member** receives Treatment for a Medical Condition that is not covered within the terms of the **Policy** , **Policyholder** remain liable for the costs of such **Treatment,** which must be settled in full upon request.

General Advice:-

Advice from the relevant professional body as to established medical practice and/ or the established medical opinion in relation to any **Medical Condition** or **Treatment.**

Geographic Area:-

The **Geographic Area** which will apply to the **Policyholder** will be shown in the Benefit Schedule.

Hereditary:-

Transmitted from parents to offspring.

Hospital:-

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

Hotline Assistance: -

Professional service center operating 24 hours, all year round, staffed with a team of Medical and Claims administrative specialists working for **NEXTCARE** to support and monitor the proper application of the Insurance **Policy**. The **NEXTCARE** provides Beneficiaries and Providers with medical and procedural guidance and information through telephone inquiries; advises claims and membership eligibility; carries out pre-approval reviews; provides appropriate authorisations; takes decision in the name and on behalf of the **Company** as to whether or not grant **Free Access** to the specific healthcare service under consideration and evaluates submitted claims in order to approve payment.

In-patient-

An **Insured Person** who stays in a **Hospital** bed and is admitted for one or more nights solely to receive **Treatment**.

Insured Person:-

Employees and their Dependants named on the **Policy Schedule**

Maternity:-

Hospital Confinement for Normal or Cesarean Delivery, Medically Necessary abortion or miscarriage and/ or any complications arising therefrom, ante – and post natal treatment as Medically Necessary.

Medical Condition:-

Any injury, illness or disease.

Medical Practitioner:-

A person who has attained primary degrees in medicine or surgery by attending a Medical School recognised by the World Health Organisation and who is licensed by the relevant authority to practice medicine in the country where the **Treatment** is given.

Medically Necessary:-

A medical service or Treatment which in the opinion of a qualified Medical Practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the **Insured persons** condition or the quality of medical care rendered.

NEXTCARE / NEXTCARE Claims Center: -

NEXTCARE is a managed care organisation and appointed to act in the name and on behalf of the **Company** in administering this Insurance **Policy** in part. Among other management services, **NEXTCARE** interfaces with the **Insured person** through a **NEXTCARE Claims Center** (referred to hereinafter as **NEXTCARE**).

Network: -

Providers forming the **NEXTCARE** Network(s) through a special and formal contractual arrangement whereby they agree to avail the **Insured Person**, usually on his Access Card presentation, with **Free Access** on a direct billing basis to their healthcare services in conformity with the terms of this Insurance **Policy** and as set forth in the **Policy Schedule** and in the **Insured Person** User's Handbook.

Out-patient:-

An **Insured Person** who receives **Treatment** at a recognised medical facility, but is not admitted to a **Hospital** bed as an **In-patient** or **Day-Patient.**

Palliative Treatment:-

Any **Treatment** given in an independent Medical Practitioners opinion for the purpose of offering temporary relief of symptoms. **Palliative Treatment** is not given to cure the **Medical Condition** causing the symptoms.

Period of Cover:-

The **Period of Cover** set out in the **Policy Schedule.** This will be a 12-month period starting from the **Commencement Date** or **Renewal Date.**

Physiotherapist:-

A person who is registered as a **Physiotherapist** and licensed to practice in the country in which **Treatment** is being given.

Policy:-

The contract of insurance between the **Company** and the **Policyholder** providing cover as detailed in this **Policy** documents. The Application Form and **Policy Schedule** form part of the contract and must be read together with this **Policy** document.

Policyholder:-

The person or company named as **Policyholder** in the **Policy Schedule**

Insurance Policy No: **CPG/10/0/001283/2013** CAREPLUS MEDICAL INSURANCE

Policy Schedule:-

The Schedule giving details of the **Policyholder** and the **Insured Persons, Policy** details and endorsements (if applicable).

Premature Birth:-

A birth that takes place before 37 weeks of gestation have passed counting from the first day of the last menstrual period (LMP).

Pre – Existing Condition:-

Any health condition known to the **Insured Person** and/or to the Policyholder which exhibited symptoms or was a consequence of injury or illness for which Medical, Surgical, and/or Pharmaceutical treatment, Medical diagnosis or advice was provided prior to the **Insured Person** first Enrolment Date under the **Policy.**

Qualified Nurse:-

A qualified resident or daily nurse whose name is currently on any register or roll of nurses, maintained by any Statutory Nursing Registration Body within the country in which they are resident.

Reasonable & Customary Charges:-

The average amount charged in respect of valid services or **Treatment** costs, as determined and substantiated by an independent Third Party Administrator.

Related Condition:-

Any injuries, illnesses or diseases are **Related Conditions** if the **Company,** on **Advice** or **General Advice,** determine that one is a result of the other or if each is a result of the same injury, illness or disease.

Renewal Date:-

The annual anniversary of the **Commencement Date.**

Specialist:-

A registered **Medical Practitioner** who-

(a) has at any time held a substantive consultant appointment in that specialty in an Hospital.

(b) has at any time held a substantive consultant appointment which the **Company** on **Advice** or **General Advice** accept as being of equivalent professional status, or

(c) is recognised as such by the statutory bodies of the relevant country.

Treatment:-

Surgical, medical or other procedures the sole purpose of which is the cure or relief of a **Medical Condition.**

SECTION II – ADDITIONS / DELETIONS

ADDITION OF MEMBERS

1. General Rule: -

The **Policyholder** may request the **Company**, by completing and signing a Request Form, accompanied with supporting documents for the addition of new Beneficiaries such as new employees, newly wedded spouse or new born children or newly adopted children of an already enrolled employee on a compulsory basis. The **Company** shall accept the request of the **Policyholder** subject to the **Policyholder's** In-house rules.

2. Eligibility: -

2.1 Employees - Only actively at work, full time employees under the age of 65 years who are residing in the UAE.

2.2 Dependants - For the purpose of this plan, dependants who are eligible for coverage are full time employee's Spouse

and their unmarried Children from the date of birth up to 18 years of age **residing in UAE**. In addition, if the children are unmarried, full time students (proof will be needed) and dependant upon you for support, they will continue to be eligible up to the age of 23 years.

3. Effective Date: -

3.1 Employees Membership - Full time employees will be covered on the date officially start at work. However, if the Employee is not actively at work on a full time basis on the date they would become a member, the commencement of the Membership shall be deferred until return to active work on full time basis.

3.2 Employees Dependants Membership - The coverage for your dependants shall start:-

1.) On the date the Employee coverage starts.
2.) On the day the Employee first acquire such dependant, from the date of birth or from date of marriage, whichever is later.
3.) On the day the dependant joins the employee officially on permanent basis in the UAE whichever is the later.

The policy allows **10 days** from date of eligibility to enroll the New Employees and dependants. If applied after **10 days**, evidence of good health, satisfactory to the **Company** is required at your expense.

4. Premium: -

The Premium relating to any approved addition shall be calculated on a pro-rata basis.

DELETION OF MEMBERS

1. General Rules: -

The **Policyholder** has the right to require from the **Company**, by completing and signing a subsequent Request Form, the deletion of Beneficiaries such as deceased or terminated employees and their Legal Dependants.

2. TERMINATION OF MEMBERSHIP: -

Membership shall automatically terminate: -
1.) If employment is terminated.
2.) If the plan terminates.
3.) When attain 65 years.
4.) Dependants membership shall terminate if the employees membership is cancelled or age limit is attained.

3. Supporting Documents: -

Submission by the **Policyholder** of supporting documents, relating to deletion requests, which are satisfactory to the **Company**, is a pre-requisite for deletion validation. Among the documents required are the Access Cards of the particular Beneficiaries.

4. Deletion Date: -

The Deletion Date of any approved deletion is the day following the date of death or termination of the Employee provided request for deletion is made promptly and Access Card returned to the **Company**. Otherwise, the Deletion Date is the date on which the Access Card is returned to the **Company**. For the Insured dependants, the **Company** shall accept deletion on the date of receiving the Access Card.

5. Liability: -

The **Policyholder** shall be the sole and fully liable party towards the Provider(s) and/or **NEXTCARE** in relation with any expenses incurred by the deleted Beneficiaries as from the Deletion Date.

To this effect the **Policyholder** should make sure that the Access Card of the **Insured Person** to be deleted has been withdrawn from the **Insured Person** and sent back to the **Company** prior to or on the Deletion Date.

6. Premium: -

The Premium refund relating to any approved deletion shall be calculated on a pro-rata basis for the period remaining after the Deletion Date. No refund is due as long as the **Insured Person**'s Access Card is not returned to the **Company**.

SECTION III – GENERAL CONDITIONS

GENERAL CONDITIONS

1. Subrogation Clause: -

If the **Company** pay benefits under this **Policy** for covered expenses incurred and it is found that **Policyholder** were repaid for all or some of those expenses by another source the **Company** will have the right to a refund from **Policyholder.** Where necessary the **Company** retains the right to deduct such refund from any impending or future claim settlements or to cancel the **Policy** void ab initio, without a refund of premium.

Other than with the **Company** written consent the **Policyholder** have no entitlement to admit liability for any eventually or give promise of any undertaking which is binding upon the **Policyholder** and/or **Dependants** and/or any other person named in the **Policy.**

2. Family Dependent Cover: -

The Employees and their Dependants (if applicable) are required to be covered under the same **Policy** with identical cover.

3. Acceptance Clause: -

Company maintains the right to ask the **Policyholder** to provide proof of age and/ or state of health of any person included in the application.

Company reserves the right to apply additional endorsements, exclusions or premium increases to reflect any circumstances the **Policyholder** advise in the Application Form or declared to the **Company** as a material fact.

4. Compliance with Policy Terms: -

Company shall not be liable under this **Policy** in the event of any failure by an **Insured Person** to comply with its terms and conditions, except where the circumstances of any claim are unconnected with such failure and no fraud is involved.

5. Change of Risk: -

The **Policyholder** must inform **the Company** as soon as reasonably possible of any material changes relating to any **Insured Person** which affect information given in connection with the application for cover under this **Policy. Company** reserve the right to alter the **Policy** terms or cancel cover for an **Insured Person** following a change of risk to the extent permissible by the laws of **Insured Person Country of Residence.**

6. Policy Duration and Premiums: -

a. The **Policy** is for one year and is renewable for successive one year period, subject to the terms in force at the time of each **Renewal Date** and to payment of the premium.
b. The premium payable may be changed by the **Company** from time to time. If the **Policyholder** move into a higher age band, the premium will increase at the next **Renewal Date**. However, this **Policy** will not be subject to any alteration in premium rates generally introduced until the next **Renewal Date**.
c. All premiums are payable in advance of any cover under this **Policy** being provided.
d. **Your Policy** is an annual contract and **Policyholder** is responsible for the whole year's premium even if the **company** have agreed that **Policyholder** may pay by installments.

7. Alterations: -

a. **Company** may alter the terms and Conditions of this **Policy** at any **Renewal Date**. **Company** will give the **Policyholder** reasonable notice of such alterations and will send details of such alterations to the last known address of the **Policyholder**. However, the alterations will take effect even if the **Policyholder** do not receive them for any reason.

b. No alteration or amendment to the **Policy** terms will be valid unless it is in writing from the **Company**.

8. Waiver: -

Waiver by **Company** in any instance of any term or condition of this **Policy** will not prevent **Company** from relying on such term or condition in other instances.

9. Cancellation: -

In the event of any non-payment of due premium within 30 days after the due date, **Company** shall be entitled to cancel this **Policy** automatically. **Company** may at own discretion reinstate the cover if the premium is subsequently paid. Whilst **Company** shall not cancel this **Policy** because of eligible claims made by any **Insured Person, the Company** may at any time terminate an **Insured Persons** cover if he/she or the **Policyholder** at any time has;

a. misled the **Company** by misstatement
b. knowingly claimed **Benefits** for any purpose other than as are provided for under this **Policy**.
c. agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to **Company** detriment.
d. otherwise failed to observe the terms and conditions of this **Policy** or failed to act with utmost good faith.

If the **Policy** is cancelled by the **Policyholder** at any time, **the Company** shall allow a pro-rata premium for the unexpired period provided the **Careplus Access Card** are returned to the **Company.**

10. Other Insurance: -

If there is any other insurance covering any of the same **Benefits**, **Policyholder** must disclose or ensure that the relevant **Insured Person** discloses the same to the **Company** and the **Company** shall not be liable to pay or contribute more than **Company** ratable proportion.

11. Fraudulent/Unfounded Claims: -

If any claim under this **Policy** is in any respect fraudulent or unfounded, all **Benefits** paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable. In addition all cover in respect of the **Insured Person** Shall be cancelled / void ab initio, without refund of premiums.

12. Liability: -

The Company's liability shall cease immediately upon termination of the **Policy** for whatever reason, including without limitation non-renewal and non-payment of premium.

13. Third Parties: -

The only parties to this contract are the **Policyholder** and the **Company**. No other person, including any **Insured Person**, has any right under this Contract to enforce this Policy or any part of it.

14. Arbitration Clause: -

14.1 General Differences:

If any difference or dispute of any kind whatsoever shall arise between the **Policyholder** and the **Company** under this **Policy** shall be referred to the decision of an arbitrator to be appointed in writing by the parties. If the parties cannot agree upon a single arbitrator, then the matter should be referred for review by two arbitrators, one to be appointed in writing by each of the parties. Should the two arbitrators fail to agree, then an independent umpire should be appointed in writing by the arbitrators. The umpire shall sit with the arbitrators and preside at their meetings and the making of an award shall be a condition precedent to any right of action against the **Company**.

If the **Company** disclaims liability to the **Policyholder** or **Insured Members** or, his/her legal personal representatives or any claimant, for any claim hereunder, and such claim is not within 12 calendar months from the date of such disclaimer referred to arbitration under the provisions herein contained, then the claim shall be deemed for all purposes to have been abandoned and shall thereafter not be recoverable hereunder.

14.2 Medically Necessary Procedure: -

In case of a difference between the **NEXTCARE**, acting as an independent administrator, and the attending Physician concerning the qualification of a service or Treatment as Medically Necessary, the parties can call for the arbitration of a Medical Committee, which will take the final decision. The Medical Committee shall be composed of three members - the attending Physician, the **NEXTCARE** Physician and a third independent Physician agreed upon by the first two.
The Committee will meet in neutral territory, and its decision will be taken by majority vote. This decision will be reported in duplicate documents, one for each party, and must be signed by all the Physicians. If any of the Physicians refuses to sign the documents, this refusal should be reported in the documents. **Both parties** undertake to accept the decision of this Medical Committee as final and binding.

15. Jurisdiction and Change Of Law: -

This policy is subject to and shall be construed in accordance with the Law of U. A. E.
If following to an amendment of the applicable law, which has come into force after the Effective Date of this **Insurance Policy**, a conflict has arisen with the conditions of this **Insurance Policy,** the **Company** may at its option, re-negotiate the conditions of this **Insurance Policy** from the date such amendment of the law becomes effective.

16. Currency: -

All monetary amounts specified in this **Policy** are expressed in the currency Dirhams, referred to herein as U. A. E. Dirhams.

17. Duties: -

Any levies on the Insurance Policy, tax or stamp duty shall be borne exclusively by the **Policyholder.**

Insurance Policy No: **CPG/10/0/001283/2013** CAREPLUS MEDICAL INSURANCE

List of Exclusions applicable under policy unless otherwise covered under the Table of Benefits

1. Maternity related medical treatment unless covered under the Maternity Benefit option
2. All Pregnancy, Maternity, Puerperium Conditions or Illnesses including Abortions except when the life of the mother would be medically endangered unless covered under the Maternity Benefit option.
3. All prenatal related tests unless covered under the Maternity Benefit option.
4. Chronic: Treatment of a Medical Condition which we our legal representative – or any other Third party acting on our behalf), on Advice or General Advice determine is Palliative treatment or a Chronic Medical Condition.
5. Pre-Existing: Any known Medical condition or related condition for which, before your start date:
   a. You have been diagnosed.
   b. You received treatment.
   c. You sought Medical Advice for, including check ups.
   d. You Needed Medical treatment (including drugs and injections).
   e. You had undiagnosed symptoms, whether recognized or not
6. Known and undeclared pre-existing conditions unless explicitly covered.
7. Suicide, self-inflicted injury, resisting legal arrest, committing an illegal act.
8. Drug, alcohol, substance abuse and addiction treatment including eating disorders, obesity, removal of fat, bulimia, anorexia nervosa and other similar disorders.
9. Organ transplantation other than heart, liver and kidney. Also the acquisition cost of such organs and all expenses incurred by the donor are excluded hereon.
10. Work related injury/accident unless otherwise claimed under the Workman Compensation Insurance Policy.
11. All ambulance services other than for cases that are deemed legitimate emergencies by the insurance company
12. All alternative medicine or therapies or treatment unless otherwise agreed.

Insurance Policy No: **CPG/10/0/001283/2013** CAREPLUS MEDICAL INSURANCE

13. In-patient companion room charges for children 16 years or older.

14. Routine medical examinations & tests including but not limited to preventative checks, screening tests, check-ups, prophylactic treatment, routine pap smears, allergy testing, pre-operative infectious disease screenings, heart scans and bone densitometry..

15. Treatment for nearsightedness, farsightedness, astigmatism, cross-eyes.

16. Durable medical equipment for home use and/or External prosthesis, aids, hearing devices, glasses, contact lenses, optical services, etc...

17. Senility related conditions including but not limited to Osteoporosis, Cataract and Alzheimer's disease.

18. Services or treatment in any long term care facility, rehabilitation centre, spa, hydro clinic, rest cures, sanatorium, home care, nursing home or home for the aged, periods of quarantine and/or isolation.

19. All gum and dental related treatment unless resulting from an accident that has occurred after the first enrolment date under the policy

20. Plastic/cosmetic surgery (including circumcision, any sinus or nasal surgery, lipomas, warts, acnes, corns, bunions, molluscum contagiosum, nevus, mole, pigmentation disorders, etc.) and treatment unless resulting from an accident that has occurred after the first enrolment date under the policy.

21. Treatment of Obesity, Removal of Fat, Bulimia, Anorexia nervosa and other identical disorders.

22. All treatment of injuries and sickness consequent to the participation of the insured either as amateur or professional in hazardous sports including but not limited to shooting, motor sports, water sports (Diving, jet-skiing, power boats, water ski), Horse riding activities (hunting, Jumping, polo), Climbing activities (mountaineering and rock-climbing), Winter sports (bob sleighing, snow boarding, ice-hockey, ski-jumping), Martial arts of all kinds, Quad bike riding, Dune bashing, Sand dune surfing

23. All conditions relating to congenital diseases or malformations as well as complications arising there from. Congenital means all diseases, anomalies, hereditary conditions including neurological disorders, chromosomal &/or genetic, defects and deficiencies present at birth either in an evident manner or in a potential manner triggered at a later stage.

24. Psychiatric illness, mental retardation, Precocious puberty, attention deficit disorders, hearing difficulties Developmental delays and/or advances and/or disturbances and/or abnormalities, whether physical, psychological, emotional, behavioral, speech or intellectual.

25. All Treatment/Tests related to sexually transmitted diseases, investigations, treatment and related complications: gonorrhea, syphilis, HPV, all Hepatitis other than Type A, AIDS, Herpes, pubic lice, trichomoniasis, cancroids whether or not active sexual transmission is documented or known.

26. Male & Female Reproductive System Disorders, Impotence, erectile or sexual dysfunction, priaprism, frigidity, ovarian cysts, Varicocele PCO... treatment or follow-up relation to sex-change procedures or operations.

27. Contraception, sterilization or reversal of sterilization, Infertility, in-vitro fertilization, GIFT, surrogacy procedures. Assisted reproduction tests, infertility/fertility tests.

28. Any pharmaceutical product not considered as medicine such as Lozenges, mouthwashes/ mouth gargles, baby formula, soaps and shampoos (both medicated and non-medicated), cosmetic preparations, antiseptic solutions, Dietary supplements, skin care products, slimming products etc.,

29. Immunomodulators and/or Immunotherapy treatment or drugs including but not limited to "Remicade, Interferon"...

30. Any drug, device, medical treatment or procedure which in the sole discretion of the Insurer is deemed to be experimental or has not been established as being effective.

31. Treatment/Tests and/or Medications of any condition that is cause by natural changes to a person body that cannot be reversed (i.e: Hormone replacement therapy for the menopause, osteoporosis, and deafness).

32. Genetic engineering and cloning.

33. Any claim in its entirety where the insured goes against medical advice.

34. Any Treatment/tests by a family, or relative member, or a physician not licensed to operate in the country where medical treatment is being delivered.

35. Any treatments/tests not related to specific symptom and/or disease.

36. Any treatment/test not required or prescribed by doctor.

37. Any treatment or test not required or prescribed by a medical physician and which is not medically necessary.

38. Any treatment/test which preauthorization has not been approved.

39. Terrorism: loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any act of terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss. An act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

40. War or Warlike operations (whether war be declared or not), or invasion, act of foreign enemy, intervention of foreign power, hostilities, mutiny, strikes, riots or civil commotion, civil war, civil uprising or looting, sabotage, rebellion, revolution, insurrection, conspiracy, usurp of power whether by political or military means, state of siege or emergency, martial law, or any of the events or causes which determine the proclamation or maintenance of state of siege or emergency and martial law, every kind of projectile, explosives, including accidental explosion and / or deliberate explosion of weapons of war, during war or directly as a result of previous war, bullets, bombs or other military devices, acts or criminal acts by armed persons whether affiliated or not to any organization or political party, or militia, or military or paramilitary organization and/or the state becoming under the control of "De facto" or "De jure" authorities acting on their own behalf or for and on behalf of other organization(s), also murder or assault or any attempt thereat, and all malicious acts of any nature whatsoever.

41. Radioactive contamination, ionizing radiation, radioactive, toxic, explosive or other hazardous properties of nuclear material thereof, and/or polluting hazardous or poisoning chemicals.

42. Diseases defined by the WHO as epidemic are excluded.

43. Multiple Sclerosis

44. Sleep Apnea and other similar sleeping disorders.

45. Parkinson Disease

46. Any Rehabilitation Treatment including Speech Therapy

47. Renal Dialysis whether short term or long term.

Insurance Policy No: **CPG/10/0/001283/2013** CAREPLUS MEDICAL INSURANCE

PHARMACEUTICAL EXCLUSION LIST

- ✓ Vitamins (unless prescribed along with antibiotics) and Minerals.
- ✓ Vaccinations
- ✓ Medication given for infertility
- ✓ Contraception/ Birth Control
- ✓ Medications for Psychiatric/ Psychological problem and Mood Altering Medications
- ✓ Soaps and Shampoos (Both medicated and non-medicated)
- ✓ Cosmetics preparations (Creams / Lotions)
- ✓ Supplementary medicines i.e. Iron, Calcium, Magnesium, etc.,
- ✓ General Antiseptic Solutions (e.g.Savlon/ Dettol)
- ✓ Tooth Brushes/ Dental Floss/ Tooth Paste
- ✓ Mouth Gargles/ Mouth Washes / Throat Spray, Lozenges
- ✓ Baby Formulae
- ✓ Contact Lens Preparations.
- ✓ Crutches, Braces, Slings, Lumbar Supports/ Corsets, Other Joint Supports,
- ✓ Support Stockings/ Pantyhose
- ✓ Breast Pumps, Massage machines, Exercise machines
- ✓ Nebulizers, Orthopaedic Shoes, Heel pad/ Arch Support
- ✓ Orthotics, Mouth Guards
- ✓ Bandages, Crepe Bandages, Supports (any type), Cervical Collars
- ✓ Hormonal Replacement Therapy
- ✓ Medicines related to Acne

Insurance Policy No: **CPG/10/0/001283/2013** CAREPLUS MEDICAL INSURANCE

SECTION V – CLAIMS PROCEDURES AND SETTLEMENT

CLAIMS PROCEDURES AND SETTLEMENT

A Personalised Access Card has been issued in the name of each **Insured Person** facilitating his/her access to any of **NEXTCARE**'s participating Network Providers with no cash payment being required except when the **Insured Person** has a deductible excess or co-participation to settle. The **Insured Person** is always requested to carry his/her **Careplus Access Card** together with a proper Identification document to be presented to Providers whenever medical treatment is needed.

A **Network** Claim, is the Eligible Expenses relating to Healthcare services rendered to the **Insured person** on a **Free Access** Basis arranged by **NEXTCARE** with the **Network Provider** on Direct Billing to the **Company**. This includes Healthcare services that are provided to the **Insured person** within the Network either by the visiting and/or honorary and/or part-time and/or community physicians and/or healthcare providers; where the **NEXTCARE** contracted Network tariff shall apply.

A Direct Claim, is the Eligible expenses directly settled by the **Insured person** and submitted by the **Policyholder** to the **Company** for reimbursement. Eligible expenses are inclusive of co-insurance, if applicable.

Out of pocket limit is the maximum aggregate amount of eligible expense the **Insured person** should bear during the policy year out of co-insurance options. This is not applicable to Maternity in hospital claims.

Treatment Outside territory for In-patient Emergency is provided to the **Insured person** while on a visit (vacation, business travel) not exceeding 60 days. Reimbursement will be based on UAE network customary charges. This coverage is not extended to **Classic** and **Deira** Plans, as these are the local plans.

Second Opinion

Coverage of certain Treatment as Network Benefits may require that the **Insured person** consult a second Network Physician prior to the scheduling of the Treatment. The **NEXTCARE** will notify **Insured person** that the particular Treatment can only be obtained subject to a Second Opinion and will inform the Policy Holder/ Insured Member of the required procedure for obtaining a Second Opinion.

In case of a difference between the **NEXTCARE** physician acting as an independent administrator and the treating physician, concerning the qualification of a Treatment

and/ or service as medically necessary and/ or appropriate, the **Company** and/ or Policy Holder/ **Company** Member can call for the Second Opinion, results of which will be final and binding.

1 In-Hospital Directives
1.1 Within Selected Territory
1.1.1 Network Claims

- If the **Insured person** chooses to be admitted in a Network Provider, upon presentation of the **Careplus Access Card,** the Network Provider will directly co-ordinate with the **NEXTCARE** for the authorisation.

- For non-emergency cases, the **Insured person** is requested to check with the Network Provider, prior to the scheduled In-Hospital/Day Care or minor procedure, treatment/admission, if the Network Provider has received the authorisation from the **NEXTCARE**. The **Insured person** may directly contact the **NEXTCARE** Claims Centre to confirm the authorisation.

- For emergency cases, upon receipt of the Hospital notification (**NEXTCARE** Pre – hospitalisation Form) from the Network Provider, the **NEXTCARE** shall immediately issue the authorisation for the eligible In-Hospital treatment.

- **Insured Person** is requested to Call **NEXTCARE** Help Line on **04-2095900.**

- **NEXTCARE** Medical and Claims Professional Staff will be receiving the call and shall provide specialised and necessary assistance for the **Insured Person's** Hospitalisation and arrange for the eligible Hospitalisation expenses to be billed directly to the **Company**.

- Unlike in U.A.E. where the **Insured Person** can directly approach a Local Network Provider, the International Network Providers require that each and every case be arranged by **NEXTCARE** prior to accepting an **Insured Person** on free access basis / direct billing.

  The **Insured Person** is requested to provide the following information:
  1. His Name and **Careplus Access Card** Number.
  2. His Telephone and Fax, when available.
  3. Name, Telephone and Fax, when available, of the treating Physician.
  4. Name of the Network Provider.
  5. Hospitalisation reasons.
  6. Date and Time of Admission.
  7. Other relevant information which may be required.

- **NEXTCARE** shall fax to the treating doctor the **NEXTCARE** Pre-Hospitalisation Form, which must be completed by the Doctor and faxed back to **NEXTCARE.**

- Once the medical information has been received by **NEXTCARE**, a decision regarding the coverage of the **Insured Person's** case shall be taken and the **Insured Person** shall be informed accordingly.

- For approved cases, **NEXTCARE** shall issue a Visa Form and arrange with the Network Provider for the direct billing of eligible In-Hospital charges.

- For declined cases, **NEXTCARE** shall issue a Denial Visa Form informing the Network Provider, the **Insured Person/Policyholder** and the **Company** that the admission is rejected and not eligible for coverage.

1.1.2 DIRECT CLAIMS/ NON- NETWORK CLAIMS

The **NEXTCARE** should be notified, at least 24 hours before a non-emergency Hospitalisation and Prior Approval should be obtained from the **NEXTCARE** before any In-Hospital services can be rendered to the **Insured Person**. For emergency cases, the **Insured Person**/his next of kin/**Policyholder** should call the **NEXTCARE** Claims Centre as soon as possible or, at the most, 24 hours within admission or prior to discharge date whichever is earlier.

- If the **Insured Person** decides to **avail** of In-Hospital services in a Non-Network Provider, he/she shall be entitled to reimbursement of all Eligible Expenses upto 80% of incurred cost.

- **For emergency cases**: In accordance with the chosen tariff up to 100% of the amount approved by **NEXTCARE** if definition is satisfying otherwise according to non-emergency cases.

- **For non-emergency cases**: 80% of incurred costs in a country where a **NEXTCARE** Network exists. 100% of incurred bills if incurred in a country where no **NEXTCARE** Network exists.

- If the **Insured Person fails** to present his/her **Careplus Access Card** to a Network provider he/she shall be entitled to 80% reimbursement of all Eligible Expenses less any deductible excess and/or co-participation calculated at the following rates.
- Reimbursement of Eligible Expenses shall be effected upon submission of the required claims documents and subject to the following conditions:

1.2 Outside Area Cover:-

Claims are not covered **Except** in case of Emergency in-hospital services he/ she shall be entitled to reimbursement 100% of all eligible expenses according to terms and conditions of this policy at **NEXTCARE** network customary rates. This coverage is not extended to **Classic** and **Deira** Plans as these are the local plans. The term **"Emergency"** shall be deemed as defined in Section 1 of this **Policy.**

2 OUT-OF-HOSPITAL DIRECTIVES

2.1 Within UAE

2.1.1 Network Claims

- Upon presentation of the **Careplus Access Card** to a Network Provider, the **Insured Person** shall benefit from **Free Access** for Eligible Expenses relating to Out-of-Hospital services prescribed on the Claim Form, except for any deductible/ excess, if applicable, which should be settled by the **Insured Person** directly to the Provider.

- For non-excluded diagnostic tests ordered by the treating Physician on the Claim Form, the **Insured Person**, is entitled to have the tests conducted without **NEXTCARE** prior approval except for procedures mentioned below/refer to point 3, Pre-Approvals.

- For non-excluded medicines prescribed by the treating Physician on the Claim Form, the **Insured Person** is entitled to get the required quantity of the prescribed drug/s considered Medically Necessary for the treatment of acute diseases usually for a period of four weeks. Prior approval is required in the event of the prescribed treatment necessitates more than one standard unit of the same medicine, except for antibiotics, antifungal agents and antiparasitic agents where prior approval is required if treatment necessitates more than two standard units.

- For chronic disease related medicines, when covered, the **Insured Person** is entitled to receive the required quantity of the prescribed drug/s up to maximum period of one month with the necessary **NEXTCARE** prior approval. If the medicines are required for more than one month, the **Insured Person**/Network Provider shall be requested to submit to **NEXTCARE** a medical report issued by the treating Physician including relevant

investigation results explaining the **Insured Person's** health condition and its history as well as the recommended treatment plan.

- **NEXTCARE** shall issue a Chronic Claim Form on a monthly, quarterly or until the expiry date of the Insurance Policy depending on the medical condition of the **Insured Person** which may require some modification on the dosage, frequency or the drug itself.

- For non-excluded cases requiring Physiotherapy prescribed by the treating Physician (not physiotherapist), **NEXTCARE** pre-approval is required before the service can be rendered to the **Insured Person**.

- For non-excluded Dental treatment prescribed by the treating Physician, Eligible Expenses incurred shall be settled as Direct Claims.

2.1.2 Direct Claims

- Upon submission of original medical report(s), bill(s) and receipt(s), a **Insured Person** is entitled to 100% reimbursement of Eligible Expenses if:

  i. A Network Provider has refused to provide free access to the **Insured Person**.
  ii. Free Access to the Network was suspended and then reinstated after the date of treatment.
  iii. Seek Services from a Non-Network Provider is entitled to reimburse a maximum of 80% of the eligible claim amount subject to deductible and/ or co-pay as applicable. This coverage is not extended to **Classic** and **Deira** Plans as these are Local Plans.

2.1.3 Out-of-Hospital Claims outside U.A.E

The International Free Access Plan is restricted to In-Hospital Benefits and applicable only for policies with International coverage. Eligible Out-of-Hospital expenses incurred outside U.A.E. within the territory of In-Hospital coverage shall be settled on reimbursement basis at 100% of eligible claim amount subject to Policy Deductible and/ or co-insurance as applicable.

2.1.4 Member Residing Outside U.A.E.

Where insurance cover has been granted for any member residing outside UAE, provided the country loading has been imposed on the member's premium, the out-of-hospital expenses will be reimbursed at 100% of eligible claim amount subject to Deductible and/ or co-insurance as applicable.

If **no** country loading is imposed on the member's premium, then the company shall reimburse a maximum of 80% of eligible claim subject to any Policy Deductible and/or co-insurance as applicable.

3. Pre-Approval for Diagnostic/Therapeutic Procedures

Notification and authorisation from the **NEXTCARE** are required for the following diagnostic/therapeutic in-patient and outpatient procedures prior to treatment.

- Angiography
- Arthogram
- Barium enema
- Barium meal
- Bronchoscopy
- Colonoscopy
- CMV
- CT-Scan
- Doppler studies
- Echocardiography
- EEG
- EMG
- Endoscopy
- Excretory urography
- FNAC
- Gastroscopy
- Herpes tests
- Holter monitoring
- Hysterosalphingography
- IVP
- Mammogram
- MCU
- MRI
- Myelogram
- Oral Cholecystogram
- Pap smear
- Rubella tests
- Sigmoidoscopy
- Stress tests
- Thyroid function tests
- Toxoplasma tests
- Hormonal Tests not related to HRT

Exception:

The procedure has been already implicitly pre-authorised in relevant in-hospital pre-approval process mentioned under points 1.1.1, 1.1.2, 1.2

4 Required Claims Documentation

For the settlement of Eligible Expenses, the **Insured Person** should submit to the **Company** the following documents within a maximum period of (60) days for claims occurred within and (90) days for claims occurred outside the UAE from date of occurrence:

- **NEXTCARE** Claims Centre authorisation (Visa) for accepted In-Hospital treatment or admission.
- Original itemised receipts and invoices.

- Full and Detailed Medical Report
- Original official results of diagnostic test.
- The treating doctor's prescription of the medicines.

Failure to submit any one of the above documents shall entitle the **Company** to reject the entire claim

5 **NEXTCARE** reserves the right to change and/or modify the claims Procedures and Settlement at any time subject (30) days notice to be given to the **Policyholder** by the **Company**.

DEFINITION OF THE TERRITORIES

Territory 1

U.A.E shall include the following

Abu-Dhabi, Ajman, Al-Ain, Dubai, Fujairah, Ras-Al-Khaimah, Sharjah, Umm-Al-Quwain

Territory 2

Arab Countries shall include the following

Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kingdom of Saudi Arabia, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Somalia, Sudan, Syria, Tunisia and Yemen, Afghanistan, Iran.

Territory 3

South East Asia shall include the following:

Bangladesh, Bhutan, Burma, India, Indonesia, Malaysia, Nepal, Pakistan, Philippines, Sri Lanka, Thailand and Vietnam.

Territory 4

World-wide excluding USA and Canada

Territory 5

USA and Canada.

Orient اوريينت

Arab Orient Insurance Company PSC

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Attached to and forming part of the Policy No. CPG/10/0/001283/2013

(Policy Period: - 3rd February 2013 to 2nd February 2014)

SOLTIUS MIDDLE EAST FZ-LLC
MATERNITY BENEFIT – CAT A & B

SCOPE OF COVERAGE: - Hospital Confinement for Normal or Cesarean Delivery, Medically Necessary abortion or miscarriage and/ or any complications arising therefrom including ante-and post natal out-patient Treatment as Medically Necessary, subject to the maximum limit as set out hereunder:-

TREATMENT ALLOWED IN PRIVATE HOSPITALS & CLINICS AS PER APPLICABLE NETWORK OF PROVIDERS

BASIS OF COVER:- Compulsory for all married Female aged 16 – 45.

LIMIT: -	**TYPE**	**LIMIT AS PER ABOVE DEFINITION**
	Normal Delivery /C-Section/ Complications of Pregnancy/ Legal Abortion/ Miscarriage	Dhs 10,000/-

WAITING PERIOD: - Nil – To cover on-going maternity cases.

DEDUCTIBLE ON OUT-PATIENT CONSULTATION :- AS APPLICABLE.

ANNUAL PREMIUM :- (Per married Female Age 16- 45) :- DHS 2,109/-

Subject otherwise to all the terms and conditions of the original Policy.

WISSAM KHALIFEH
ASSISTANT GENERAL MANAGER
MEDICAL DEPT.

SOLTIUS MIDDLE EAST FZ-LLC

Attached to and forming part of the Policy No. CPG/10/0/001283/2013

(Policy Period: - 3rd February 2013 to 2nd February 2014)

BENEFIT SCHEDULE – CLASSIC PLAN - CATEGORY - A

The following Benefits Schedule should be read together with the whole of the Policy wording, particularly the Definitions and it shall override the Policy Wordings wherever deemed necessary.

	TYPE OF SERVICE & BENEFIT	COST, CHARGES AND FEES PAYABLE
1	**Maximum Annual Aggregate Benefit Level** **i) In-Patient Limit** **Room & Board Class** **ii) Out-Patient Limit**	**AED. 100,000/- per member** **Private Room** Unlimited visits.
2	**i) Geographical Territory Elective / Non Emergency / Emergency** **ii) Restricted to Emergency Treatment whilst traveling outside of country of normal residence either on vacation or business up to a maximum stay of 60 days per trip.**	UAE, Arab Countries, South East Asia, Indian Sub-continent ii) World-wide Excluding USA & Canada and claim will be reimbursed at 100% of the the equivalent of the applicable Network charges.
3	**i)Consultations including initial consultations and examinations in respect of a medical condition.** **ii)Out-Patient Medicines and Drugs combinedwhich require a prescription including any state Health Service charges for such Medicines and Drugs. (Except those being listed on the Third Party Administrator list of exclusions)** **iii)Prescribed Out-Patient Diagnostic Tests** **iv) Prescribed Out-Patient physiotherapy treatment**	FULL REFUND FULL REFUND FULL REFUND Full refund but limited to 15 sessions per illness.
4	**Contribution per person :** **i) Deductible applicable on Physician consultation** **ii) Co-Insurance applicable on Pharmaceuticals, Diagnostic tests and Physiotherapy**	**AED. 50/-** Nil

SOLTIUS MIDDLE EAST FZ-LLC

Attached to and forming part of the Policy No. CPG/10/0/001283/2013

(Policy Period: - 3rd February 2013 to 2nd February 2014)

BENEFIT SCHEDULE – CLASSIC PLAN - CATEGORY - A

5	**Accommodation charges incurred as an In-Patient or as a Day-Care Patient on a per day basis in a Private Room**	FULL REFUND
6	**Approved Ancillary Charges incurred as an In-Patient or Day-Care Patient**	FULL REFUND
7	**Prescribed medicines and drugs combined administered whilst an In-Patient or Day-Care Patient and charged separately.**	FULL REFUND
8	**Surgeon's and Anaesthetists' Services**	FULL REFUND
9	**Specialist Physicians' Services for In-Patient Treatment**	FULL REFUND
10	**In-Patient Specialist Services including consultations and Diagnostic Procedures as recognized by T.P.A. administration.**	FULL REFUND
11	**Radiotherapy, Chemotherapy and Computerised Tomography received as an In-Patient OR Out-Patient as referred by an approved Specialist.**	FULL REFUND
12	**Pre-approved Minor Surgical Procedures undertaken by a General Practitioner at a Recognised Medical Facility, Hospital or Private Hospital.**	FULL REFUND
13	**Treatment at any State Health Service/ Government Hospitals.**	Reimbursed up to a maximum of the applicable UAE Network charges / rates.
14	**Reasonable charges necessarily incurred for the use of private road ambulances in the time of an emergency.**	FULL REFUND
15	**Home Nursing Care if medically necessary**	FULL REFUND (Subject to a max of 13 Weeks of such Nursing per Member or Dependant per Period of Insurance)
16	**In-Patient Parent / Companion accommodation for child up to age 16 years**	UAE Dhs. 300 per night (subject to a max of UAE Dhs. 3,000 per Period of Insurance)

SOLTIUS MIDDLE EAST FZ-LLC

Attached to and forming part of the Policy No. CPG/10/0/001283/2013

(Policy Period: - 3rd February 2013 to 2nd February 2014)

BENEFIT SCHEDULE – CLASSIC PLAN - CATEGORY - A

17	**Organ Transplant Limit (as recipient) for Heart, Liver & Kidney only**	Fully covered up to Annual Benefit Level
18	**Dental Treatment: Costs charges and fees for dental treatment will be restricted to those incurred in an emergency for the immediate relief of pain as a result of an accident only.**	Full Refund, however, any surgery must be performed within 7 days from the date of accident.
19	**AlternativeTreatment restricted to Chiropractory and Osteopathy**	Upto limit of Dhs. 1,600/- Per Person Per Annum, however, purely on reimbursement basis
20(i)	**BASIS OF CLAIM SETTLEMENT :-** **IN-PATIENT BENEFIT** **Network - Within UAE** **Non-Network (within UAE)** **Treatment at Government Hospitals** **Outside UAE within Geographical Scope of Territory**	 100% covered under Free Access Plan. 80% of the equivalent of the UAE General Network tariff rates unless it is an Emergency as defined in the Policy and the reimbursement will be based on 100% of the **General Network** rates. Reimbursed at 100% of UAE General Network rates 100% reimbursed as cost incurred subject to the applicable deductible / co-charges as per the terms and conditions in the Policy not exceeding 100% of UAE General Network rates.
20(ii)	**OUT-PATIENT BENEFIT** **Network - Within UAE** **Non-Network (within UAE)** **Treatment at Government Hospitals**	 100% covered under Free Access Plan. 80% of the equivalent of the UAE General Network tariff rates unless it is an Emergency as defined in the Policy and the reimbursement will be based on 100% of the **General Network** rates. Reimbursed at 100% of UAE General Network rates

SOLTIUS MIDDLE EAST FZ-LLC

Attached to and forming part of the Policy No. CPG/10/0/001283/2013

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BENEFIT SCHEDULE – CLASSIC PLAN - CATEGORY - A

	Outside UAE within Geographical Scope of Territory	100% reimbursed as cost incurred subject to the applicable deductible / co-charges as per the terms and conditions in the Policy not exceeding 100% of UAE General Network rates.
21	**Type of Network Of Providers**	**General Network.**

The scheme includes chronic and pre-existing disease/illness up to the Annual Benefit Level.

Note: All Full Refunds are subject to not exceeding the Maximum Aggregate Annual Benefit Level. Further the rates, benefits and terms stated in this quotation are not applicable for Abu Dhabi and Al Ain based members

AUTHORISED SIGNATORY