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DUBAI INSURANCE

CONTRACT

This Policy Agreement together with the Application Form and Policy Schedule / Certificate of Insurance constitutes the Contract between the Insured Company / Person and the Insurer. The Plan selected will be shown on the Certificate of Insurance.

A Certificate of Insurance will only be issued when an Insured Person has completed an Application Form that has been accepted by the Insurer and the required Premium has been paid.

The currency of this Policy is expressed in **AED**.

OTHER INSURANCE

If, at the time of loss, the Insured Person has insurance from another source for benefits provided under this Policy, the policy with the earliest effective date will be deemed to be first payer. Any benefits payable by the following shall not be considered as a covered cost under this policy:

- Any group or individual Hospital or Medical Plan.
- Any government Hospital or Medical Plan.
- Any Worker's Compensation Act.
- Any public or tax-supported agency.

ADDITIONS AND DELETIONS

Additional Insured Persons will be covered automatically subject to eligibility criteria. Any Insured Persons added to or deleted from the insurance coverage shall be reported immediately and not later than the end of the month during which addition/ deletion took place. The applicable premium portion shall be calculated on a pro-rata basis.

GENERAL PROVISIONS AND LIMITATIONS

- **Arbitration**: Any differences with respect to medical opinion will be settled between two medical experts appointed by the two parties. This dispute resolution will be in writing. Any differences of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing at the outset by the two medical experts.

- **Legal Proceedings**: No legal proceedings shall be commenced until 60 days after a claim has been correctly submitted and no such action shall be brought unless commenced within 3 years from the first date of treatment.

  This Policy is governed by the Laws of UAE and any dispute arising out of this Policy shall be settled in the courts of Dubai.

- **Pre-Authorization**: All In-patient and Day-patient hospitalizations, special Out-patient services (each outpatient procedure that exceeds AED 1000) benefits must be pre-authorized and arranged in advance by MSH

- **Identification of Insurer / Action against Insurer**

  This insurance has been effected in accordance with the authorization granted to the undersigned by certain Underwriters, whose definitive members and proportions underwritten by them can be ascertained by references to this policy which bears the seal of the Policy Signing Officer and has been certified by the Underwriter's Attorney In Fact in the UAE and may be seen at the office of the undersigned. The Underwriters identified in the said contract shall be liable hereunder each for his own part and not one for another in proportion to the several sums by each of them subscribed to the said contract.

DEFINITIONS

Subject to provisions that are contrary or additional to the Schedule of Insurance, for the application of the Policy, the following terms are assigned the following meanings:

- **Accidental Damage to Natural Teeth**: When an accident or blow to the mouth or face results in an injury to a tooth, the Policy will pay for dental treatment to restore or replace permanently attached artificial or sound teeth. Such treatment must be commenced within 30 days of the accident and must be performed by a dental practitioner. Detailed medical documentation from the physician or dentist must be provided to support an Insured Person's claim.
- **Ambulance Charges:** Charges for licensed ground ambulance transportation to the nearest Hospital, or from one Hospital to another or from a Hospital to the Insured Person's residence.
- **Application Form for Insurance (herein referred to as Application Form):** A signed statement of facts duly completed and signed by the potential Policyholder / Insured that may or may not include Evidence of Insurability documents which are requested by the Insurer and serves as the basis on which the Insurer conducts Underwriting and decides whether or not to issue this Contract to the potential Policyholder (such as a Medical Questionnaire of each Insured, , the school certificate or photocopy of the student card for the ongoing year when there are dependent children, as well as any other document allowing the Beneficiaries to justify their capacity of Beneficiaries). Once an Insurer decides to issue this Contract, the Application Form/s becomes an integral part of this Contract and the potential Policyholder / Insured is thereafter referred to as Policyholder / Insured Person.
- **Benefits:** Any covered expenses / services that are medically necessary and the Insurer will pay under the Benefit Plan wording of this Policy.
- **Biological Agen**t: Any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.
- **Chemical Agent:** Any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.
- **Chronic Condition:** Any Injury or Sickness which requires medical attention, monitoring, or treatment for a period exceeding 90 consecutive days AND/OR
  A disease, illness or injury that has at least one of the following characteristics:
  - it continues indefinitely and/or is permanent
  - it recurs or is likely to recur
  - you require to be rehabilitated or specifically trained to cope with it
  - it requires long term monitoring, consultations, check-ups, examinations or tests

- **Complementary Therapy** includes:
  - Acupuncture
  - Chiropractor
  - Homeopathy
  - Osteopathy

  Such treatments must be referred by a licensed physician. Providers of these therapies must be licensed or legally qualified in the country in which the therapy is provided.

- **Congenital Condition:** A medical condition or abnormality that is present at birth, whether it is hereditary or the result of an environmental factor

- **Co-payment:** The specific percentage of money the Insured is required to pay towards a covered benefit per year.

- **Day Patient, Day-care and Day-case Surgery:** Treatment where it is medically necessary for a patient to occupy a Hospital bed, however an overnight stay is not required.

- **Deductible:** The dollar amount for which the Insured Person is liable, as stated on his / her Confirmation of Insurance / Certificate of Insurance before any remaining eligible expenses are reimbursed under this Policy.

- **Dental Treatment (Minor)**: Where selected / included and shown on the Insured Person's Certificate of Insurance. This includes basic routine and preventive services as follows:
  - Complete oral examination once per year
  - Intraoral radiographs
  - Panoramic radiographs once per year
  - Extraoral radiographs
  - Scaling and polishing once every 6 months for dependent children and once every 9 months for adults
  - Prophylaxis
  - Space maintainers (for children)
  - Root canal treatment (endodontic)
  - Topical application of fluoride once every 6 months for dependent children and once every 9 months for adults
  - Simple extractions
  - Pit and fissure sealant on bicuspids and permanent molars, once every 3 years for dependent children only
  - Amalgam and tooth coloured fillings
  - Oral hygiene instruction, once in a lifetime

- **Dental Treatment (Major)**: Where selected / included and shown on the Insured Person's Certificate of Insurance. This includes:
  - Metal, plastic, porcelain and ceramic crowns
  - Posts and cores
  - Inlays and Onlays
  - Implants and related surgical grafts
  - Major surgeries (impactions, remodeling, excision, removal, reduction or augmentation of the alveolar bone, remodeling of the floor of the mouth, sinus lift, gingivoplasty, apicectomy)

- **Dentist:** A dentist, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the treatment is provided.

- **Dependent:** The spouse of an Insured Person (but excluding those legally separated), and under the age of 75 for Essential and Medium plans, and under the age of 71 for the Optimum plan. Unmarried children, step-children, foster children and legally adopted children, who are dependant on the Insured Person for support, provided that such children are not less than 15 days old (unless birth of newborn is an insured event under this policy in which case newborn is insured under Maternity Benefit to date of discharge from hospital) and not more than 18 years old at the date the Policy was purchased (or 24 years old provided it can be proved that the child is continuing in full-time education).

- **Diagnostic Services:** Medically necessary laboratory tests and x-ray services, radiographs and nuclear medicine procedures used to diagnose and treat medical conditions.

- **Effective Date:** The date on which the coverage under this Policy begins, as specified on the Confirmation of Insurance / Certificate of Insurance.
- **Emergency:** A sudden and unexpected turn of events or change of condition which requires immediate Medical Treatment and which first manifests itself while this Policy is in force
- **Emergency Dental:** Treatment received during the emergency first visit after the onset of acute dental pain. Such procedures may include:
  - avulsed tooth
  - dry socket
  - acute abcess swelling
  - cracked root
  - exposed dentin
  - food impaction
  - mandibular dislocation
- **Emergency Security Situation:** A civil and / or military uprising, insurrection, war, revolution, or other violent disturbance in a Host Country, which in the opinion of either the recognized governmentof the Insured Person's Home Country or Host Country immediate evacuation is advised. Emergency Security Situation does not include natural disasters.
- **Health :** The past and current status of health of the Insured to be declared by him/her in the Application form.
- **Home Country:** The country for which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be taken to mean the country that the Insured Person has declared on the Application Form. Where a family is to be covered by the Policy there will be deemed to be one Home Country for that family, which will be the Home Country declared on the Application Form.
- **Home Nursing:** The reasonable and customary cost for the medical services of a licensed nurse in the Insured Person's home when prescribed by a physician and related directly to a medical condition for which the Insured Person has received or is receiving treatment covered under this policy. The nurse cannot be an immediate family member or currently residing with the Insured Person.
- **Hospital:** Any medical or surgical institution which is legally licensed as a hospital in the country in which it is located and whose main activities are not those of a rehabilitation centre, spa, hydro clinic, sanatorium, nursing home or home for the aged. It must be under the constant supervision of a resident Physician.
- **Hospital Services:** Costs for accommodation in a single private room, nursing, operating theatres, intensive care unit, surgeons' and anaesthetists' fees, drugs, dressings, diagnostic procedures or any other necessary charges made by the Hospital for medically necessary Treatment.
- **Host Country:** Refers to the Country where the Insured Person is living and working.
- **Immediate Family Member:** Refers to spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother of the Insured Person.
- **Injury:** An unexpected and unforeseen harm to the body caused by an Accident occurring while the Policy is in force and resulting, directly and independently of all other causes, in the Insured Person incurring Medical Expenses.
- **In-Patient:** A patient who occupies a Hospital bed for more than 24 hours for medically necessary Treatment and for which admission was recommended by a Physician or Surgeon.
- **Insured Person / You / Your:** Wherever used in the Policy means an eligible person as defined in the ELIGIBILITY section of this Policy for whom cover has been confirmed and a Confirmation of Insurance / Certificate of Insurance issued
- **Insurer:** Dubai Insurance Company who provides this insurance.
- **Intensive Care Unit**: Cost of treatment in an intensive care unit, intensive therapy unit, high dependency or coronary care unit where this is an essential part of the Insured's treatment and is

routinely required by patients undergoing the same type of treatment. Or, where it is medically necessary in the event of unexpected circumstances e.g. an allergic reaction during surgery.

- **Maternity Care (routine):** Wherever used in the Policy refers to the medically necessary expenses associated with pregnancy and childbirth. These include:
  - Ante-natal care
  - Hospital charges, obstetricians' and midwives' fees
  - Post-natal care required by the mother immediately after birth
  - New born accommodation

  No cover is provided for elective Caesarean section.

  No coverage for expenses incurred outside the Host Country is provided unless pre-approved by MSH.

  The newborn is insured under this benefit until discharged from hospital. Application must be made and underwriter's acceptance received for continuation of coverage for the newborn under the main policy, subject to the applicable premium being paid. Cover can be effective from the date of birth subject to the application for the newborn having been submitted within 15 days of the date of birth. Newborns will not be added to cover unless a specific request to do so is received.

- **Maternity Care (complicated):** Wherever used in the Policy refers to the medically necessary expenses associated with an abnormal pregnancy or delivery. Pregnancy and childbirth complications are defined as any medical condition relating to pregnancy that if not immediately treated will threaten the life of the mother or unborn child and include:
  - Pre-eclampsia
  - Miscarriage / threatened miscarriage
  - Still birth
  - Heavy bleeding immediately following childbirth
  - Afterbirth left in the womb following delivery of the baby
  - Congenital conditions

  Other conditions arising from pregnancy or childbirth which could also develop in people who are not pregnant are not covered under this benefit but may be covered elsewhere under the Policy.

  No cover is provided for elective Caesarean section.

  No coverage for expenses incurred outside the Host Country is provided unless pre-approved by MSH.

  The newborn is insured under this benefit until discharged from hospital. Application must be made and underwriter's acceptance received for continuation of coverage for the newborn under the main policy, subject to the applicable premium being paid. Cover can be effective from the date of birth subject to the application for the newborn having been submitted within 15 days of the date of birth. Newborns will not be added to cover unless a specific request to do so is received.

  Once a pregnancy has complications, the balance of that pregnancy and any previously incurred expenses will be adjudicated under the Complicated Maternity benefit.

- **Medical Appliances:** Minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, orthotics and the temporary rental of a wheelchair when prescribed by a Physician or Surgeon.
- **Medical Expenses:** Medical and related expenses for which coverage is provided under the Benefits Section of this Policy which are necessarily incurred as a result of Injury or Sickness while coverage is in force under this Policy as to the Insured Person.
- **Medical Supplies & Services:** All supplies considered as medical treatment and all equipment primarily intended to improve a medical condition or injury.
- **Medically Necessary:** A service, confinement or supply that is prescribed by a medical practitioner for the diagnosis or treatment of sickness, disease, illness or bodily injury and which is considered to be orthodox treatment for the condition being treated or diagnosed.

- **Medical Practitioner:** A doctor who is registered or licensed to practice medicine under the laws of the country, state or other regulated area in which the treatment is provided
- **Medical Treatment:** Surgical or medical procedures the sole purpose of which is the cure or relief of an acute Sickness or Injury. An acute Sickness or Injury is characterized by an occurrence of brief duration, after which the Insured Person returns to his / her normal or previous state and degree of activity.
- **Newborn Child:** A baby who is within the first fifteen days (15) of its life following delivery.
- **Newborn Nursery Care:** Medically necessary expenses associated with the care and treatment of a newborn child while in hospital immediately following birth and any medically necessary expenses incurred up to the guaranteed period of coverage provided under the Maternity Care Benefit.
- **Nuclear, chemical, biological terrorism:** The use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.
- **Out-Patient Treatment:** Medically necessary treatment and diagnostic services at a hospital or other medical institution or Physician's office where it is not necessary for the Insured to be admitted or confined to a Hospital bed as an In-Patient or Day-Patient.
- **Overall Maximum Limit:** The total aggregate benefit limit that may be claimed as the result of any one Injury or Sickness by an Insured Person. Such limit for your specific level of cover is indicated in the Table of Benefits of this policy.
- **Parent Accommodation**: When an Insured Person under 18 years of age is confined to Hospital as an In-Patient, the Insurer will pay the reasonable and customary costs charged by the Hospital for one parent to stay with the child. Further, if an Insured Person who is a single parent is confined to a Hospital as an In-Patient, the Insurer will pay the reasonable and customary costs for a Dependent child under 18 years to stay with such Insured Person.
- **Physician or Surgeon:** A legally licensed medical practitioner recognized by the law of the country where treatment is provided and who, in rendering such treatment, is practicing within the scope of his / her licensing and training. A Physician or Surgeon must not be the Insured Person or an Immediate Family Member of an Insured Person.
- **Policyholder:** The individual or company / organization to whom the Policy has been issued and who is named on a valid Confirmation of Insurance / Certificate of Insurance.
- **Pre-existing Condition**: Any known medical condition (or related condition) that has been diagnosed, required medical treatment, medical advice, check-ups or where medical advice should have been sought following recognized clinical procedures prior to the start of cover. Any medical condition where the Insured Person has experienced symptoms prior to the start of cover.
- **Prescription Drugs:** Drugs, medicine, serums, vaccines and dressings prescribed by a physician for medically necessary covered treatment.
- **Prosthesis:** A device that replaces part of the human body because a part of the body is permanently damaged, is absent or is malfunctioning.
- **Reasonable and Customary Costs:** Costs incurred for approved, eligible treatment or supplies that do not exceed the standard costs of other providers of similar standing in the same region, for the same treatment of a similar Sickness or Injury.
- **Renewal Date**: The date shown on the Insured Confirmation of Insurance / Certificate of Insurance when the policy falls due for renewal.
- **Sickness:** Any unexpected and unforeseen illness or disease manifesting itself while this Policy is in force as to the Insured Person and which causes the Insured Person to incur Medical Expenses.
- **Well Baby Care:** The customary medical program recommended for all newborns, including checkups and immunizations.

- **MSH:** The Third Party Administrator and claims administrator appointed by the Insurer.
- **Accident**: any bodily injury independent of the Insured's will, resulting from the sudden and unforeseeable action of an external cause. **Heart attacks and sudden pathologies are not regarded as accidents.**
- **Policyholder:** physical person or legal entity whose registered office is (...) and who, through its duly authorised legal representative, has acquired the Policy in favour of a category of its employees (Category), and who pays the premiums thereof.
- **Member**: a physical person who adheres to this Policy, pays his/her premiums and benefits from the advantages provided by it.
- **Insured:** an individual mentioned on the Insurance Certificate for whom a contribution is paid by the Member and on whom the risk is based. This refers to the Member and his or her Beneficiaries (spouse and dependent children, as defined in Article 6.2 of Title I).
- **Beneficiary**: The Beneficiary of the Death benefit in the covered benefits is the party designated by the Member in the Beneficiary Clause or, failing that, in the standard clause contained in the Application form.
- **C.F.E.**: *Caisse des Français de l'Etranger* [French Social Security Department responsible for medical insurance of expatriate French citizens]
- **Insurance Certificate**: this document specifies the benefits granted by the Insurer or by its Agent, as well as the data concerning the Member and the Beneficiaries mentioned therein.
- **Policy**: the Group Insurance Policy with optional coverage governed by the General Conditions and Schedule of Insurance.
- **Agent**: third party mandated by the Insurer to manage the tasks entrusted to it.
- **Eligible Health Institution**: a public or private health institution (hospital or clinic) which, on the one hand, is authorised to perform acts and provide medical treatment for sick or injured persons and, on the other hand, holds all of the administrative and health authorisations required for this purpose.
- **Unusual or unreasonable charges**: medical expenses which do not correspond to the rates normally charged for a service or similar service and which exceed the normal rates for such a service or benefit under the best possible conditions in the location where the service is administered.
- **Deductible Period**: uninterrupted period of work stoppage, at the end of which the Insurer pays the Member a daily allowance.
- **TTI**: Total Temporary Incapacity for work.
- **Hospitalisation**: stay as a patient prescribed by a doctor in an Eligible Health Institution, provided that the purpose of this stay is the medical or surgical treatment of a disease or the consequences of an Accident.
- **Unexpected Illness**: sudden and unforeseeable deterioration in the Insured's health, as determined by an authorised medical authority.
- **Information Notice**: document which defines the benefits and their procedures for entry into effect, as well as the formalities to be completed in the event of a claim. It shall mandatorily be drawn up by the Insurer, then provided by the Policyholder or by his/her Agent to Members, before the conclusion of the Policy.
- **PACS:** Civil Solidarity Pact as defined by articles 515-1 et seq. of the French Civil Code, registered and published in accordance with the provisions of the said code.
- **Civil partnership registered overseas:** Conjugal life commitment under foreign law*, established by two natural persons (not a PACS as defined hereinabove and exclusive of marriage), provided that it meets all the following conditions:
  - it should be registered in a registry before a public authority of a foreign State other than France.
  - it should have been subject to all formalities of disclosure in the State of the public authority that registered it.
  - It must be compliant with French public policy*, and in particular, must not have been established between persons defined in article 525-3 of the French civil code.

* In accordance with the provisions of article 515-7-1 of the French Civil Code, the conditions of formation and the effects of a registered partnership as well as the causes and effects of its dissolution are subject to the substantive provisions of the State of the authority that registered it.
However, the recognition of the foreign Civil Partnership is contingent upon it not being contrary to French public policy.

- **Coverage Period**: period during which the Insurer is contractually required to indemnify the risks, which may arise during the performance of the Policy. The Risk Coverage Period shall begin no earlier than the date shown on the Insurance Certificate and end no later than the end date of application.
- **TILA**: Total and Irreversible Loss of Autonomy.
- **Medical Questionnaire**: a document containing the medical history enabling the Insurer's Medical Adviser or its Agent to assess the health risk represented by a potential Insured. It must be less than one month old on the date of enrolment.
- **Rehabilitation**: the Insured who has undergone surgery may only benefit from rehabilitation sessions at a rehabilitation centre after hospitalisation.
- **Base Salary**: the Member's total gross annual remuneration.
- **Post-operative care and follow-up**: the Insured who has undergone surgery may benefit from post-operative care and follow-up, understood as: home nursing care, as well as mandatory visits and consultations with doctors after surgery. These shall occur immediately after or instead of treatment at the hospital, in order to enable the Insured to regain the autonomy of his/her body or part of his/her body affected by the operation. Only post-operative care and follow-up, which the doctor who performed the procedure considers medically necessary for the Insured's normal recovery shall be reimbursed.
- **Geographical Benefit Area**: The United Arab Emirates.

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DUBAI INSURANCE

TITLE I
GENERAL PROVISIONS

THE POLICY

ARTICLE 1 - OBJECT OF THE POLICY

1.1 This Policy has the following object:

- payment of benefits in reimbursing Health Expenses incurred during the Coverage Period by Members, as well as their Beneficiaries residing in the same Country, when the latter are registered in the Policy.
  The benefits provided in this Policy shall be paid in addition to the reimbursements of the C.F.E.
- the payment of a death benefit, daily allowances and a pension within the context of the optional pension benefit.

1.2 The benefits shall be exercised within the limit of the level of coverage chosen by the Member:

1.2.1 Health benefits

Health benefits shall be exercised within the limit.

- **Compulsory level of benefit : Hospitalisation and Medical Expenses**

- **Optional benefits: Optical/dental benefits**

This option is intended to improve reimbursements. The level of option may be chosen regardless of the compulsory level of benefits. Option reimbursements shall be added to the basic repayments.
It is possible to add the **Optical and Dental** benefit, nevertheless it cannot be chosen alone but shall necessarily in addition the Hospitalisation and Medical Expenses benefit.

1.2.2 Death and Disability benefits

Death and Disability benefits are optional. They may only be chosen with the compulsory Health benefits.

Death - Total and Irreversible Loss of Autonomy: this benefit is intended for payment of a lump sum to the designated Beneficiary/Beneficiaries in the event of the Member's Death. The capital shall be paid to the Member in advance in the event of a Total and Irreversible Loss of Autonomy (TILA).

Total Temporary Work Incapacity (TTI) - Permanent Disability: this benefit is intended to pay daily allowances to the Member in the event of the Member's TTI or Permanent Disability.
The TTI benefit - Permanent disability can only be chosen as a supplement to the Death - TILA benefit.

1.3 This Policy consists of:

- the General Conditions, defining the reciprocal obligations and all of the benefits which may be subscribed;
- the Schedule of Insurance, specifying the benefits actually subscribed, as well as the beneficiaries of these benefits and the amounts of benefits and premiums, where applicable, amending or waiving the terms of the General Conditions;
- any amendment subsequently drawn up and annexed to the Policy, amending the General and/or Schedule of Insurance.

Notice to the Insured Person: If you are hospitalized, do not assume that someone has contacted the Insurer on your behalf. It remains your responsibility to ensure that the Insurer or its authorized representatives have been contacted prior to admission or as soon as reasonably possible, failure to do so could affect settlement of your claim.

ARTICLE 2 - LAW APPLICABLE TO THE POLICY

This Policy shall be governed by and interpreted in accordance with UAE law.

ARTICLE 3 - UNCHALLENGEABILITY OF THE POLICY - MAINTENANCE OF BENEFITS

3.1 The declarations of the Policyholder and the Members shall serve as the basis for this Policy, which shall become unchallengeable as soon as it takes effect.

3.2 Except in the event of withholding or deliberate false or inaccurate declaration or omission, made in bad faith by the Member, this latter party, once admitted, may not be excluded from insurance cover against his/her will for as long as he/she is part of the insurable category, and provided that the premium has been paid.

ARTICLE 4 - EFFECTIVE DATE, DURATION AND RENEWAL OF THE POLICY

4.1 This Policy takes effect at 00:01 hours, on the effective date mentioned in the Schedule of Insurance and ends at 00.01 hours on the first anniversary thereof, provided that the first premium was paid.

4.2 Coverage may be renewed subject to approval by the Insurer for further consecutive terms, not exceeding 12 months, on payment of premium at the rate and in the amount determined at the time of renewal by the Insurer.

4.3 Each Party has the right to terminate the Policy at the time of its annual renewal.

ARTICLE 6 - CONDITIONS OF ADHESION TO THE POLICY

6.1 In order to adhere to the Policy, Member shall meet the following cumulative conditions:

- residing outside of their Home Country or pre-approved local national
- be between 18 and 74 years of age for Essential and Medium plans on the date of inception, and aged between 18 and 70 years of age for Optimum plan on the date of inception
- complete and sign the Application Form in acceptance of the Policy Terms & Conditions and received underwriter's acceptance
- have paid the required premium or had such premium paid on their behalf by the Policyholder

And in addition, for the Total Temporary Work Disability - Permanent Disability benefit:

- be under 63 years of age on the day of adhesion;
- be an employee and not be a majority shareholder of the company which employs him/her.

6.2 The following parties shall be regarded as **Beneficiaries** and may therefore benefit from the benefits subscribed by the Member:

- the Member's spouse: a spouse who is not legally separated (subject to providing a sworn declaration of non-separation), a partner bound by a Civil Solidarity Policy (PACS) (subject to providing a copy of the agreement registered at the Registry of the Court of First Instance of the common domicile), or a common-law spouse (subject to providing proof of joint domicile and a sworn declaration of a common-law marriage) with a maximum age of 70;

NB: when the Policy is subscribed as a supplement to the C.F.E. and the spouse is not recognised by one of these organisations as being "dependent" on the Member, the spouse may enjoy the benefits provided that he/she is individually affiliated with this basic organisation.
Only one person shall be covered as the "spouse" of the Member by way of this Policy.

- dependent children: the Member's and/or spouse's children, dependent for tax purposes on the Member and/or spouse, until their 16th birthday in all cases, and until their 20th birthday if they are pursuing secondary education (subject to providing a current school certificate or a photocopy of a student card for the current year).

NB: when application of this Policy is in addition to the C.F.E., the benefits of dependent children may be maintained beyond their 20th birthday only if they are individually registered with this basic entity.

The Member's spouse and dependent children shall reside in the Member's Geographical Benefit Area or country of origin in order to be eligible for benefits.

ARTICLE 7 - ADMISSION TO INSURANCE COVER

7.1 When insurance is established, the person to be insured shall submit to the Insurer or to his/her Agent:

- the **Application Form**, completed and signed by the Member;
- the **Medical Questionnaire** if any, which is less than one month old, completed and signed by each Insured, it being understood that each Medical Questionnaire shall be forwarded in a confidential envelope to the Insurer's Medical Adviser or his Agent;
- the **school certificate** for the current year or a photocopy of the **student card** for the current year when dependent children are covered by this Policy (as defined in Article 6.2 above).
- the **Payment Proof**
- the **PDC cheques**
- the **Signed Quote**
- the **Financial Summary**
- the **Continuity Certificate (COC)** for Abu Dhabi Holding Visa
- a **valid passport**
- a **valid Employment VISA / Resident Visa / Entry Visa**
- a **valid EID / Application Form**
- the **valid trade / Commercial License** - for corporation only
- the **valid Establishment Card** - for corporation only
- the **Ministry of Labor List (MOL)** (not applicable for Free Zone) - for corporation only
- An **undertaking letter** (Free Zone) - for corporation only

The Insurer or its Agent may request the forwarding of any supplementary information which it considers useful for the study of the file and for the assessment of the risk. In the same way, the Insurer or its Agent reserves the right to ask the Beneficiaries to provide any other document enabling them to prove their status as Beneficiaries.
All of the documents provided to the Insurer or his Agent shall constitute the **Application Form**.

7.2 The Member shall be required to notify the Insurer or its Agent in writing of any change of address, Host Country and/or status and to inform the Insurer or its Agent of any changes relating to his/her family situation.
Declarations and notifications made during the performance of this Policy shall only be effective if they have been received in writing by the Insurer or its Agent.
7.3 No medical information concerning the Insured may be notified to the Policyholder or to his/her Agent. The Policyholder, his/her Agent and the Insurer undertake to respect this obligation of confidentiality.

7.4 After studying the Application Form, the Insurer or its Agent shall notify its acceptance by issuing an **Insurance Certificate** mentioning the Coverage Period, the surname and first name(s) of the Insured (Member and Beneficiaries), the benefits subscribed, the Host Country, as well as the amount of the premium.

7.5 According to the results of the medical selection, the Insurer or its Agent reserves the right:

- to apply an additional premium to the amount of the premiums;

ARTICLE 8 – EFFECTIVE DATE, DURATION AND RENEWAL OF INSURANCE

8.1 For the Member, the effective date of insurance begins on the date indicated on the Insurance Certificate and at the earliest on the first day of the calendar month following receipt by the Insurer or its Agent of the complete Application Form (in accordance with Article 7.1 above), subject to acceptance of the insurance following medical selection, payment of the first premium and opening of rights to the C.F.E., as appropriate.

8.2 For the Beneficiaries of the Member, the effective date of their registration shall begin under the same conditions as those of the Member's application (article 8.1 above). In the event of a change in the family situation (marriage, conclusion of a PACS, common law partnership or birth of a child), the registration of the Beneficiaries shall enter into effect within one month of the express acceptance of their registration by the Insurer or by his/her Agent.
For the Member's children born after his or her adhesion to the Policy, they shall be regarded as admitted provided that their birth is declared to the Insurer or his or her Agent within one month of their date of birth.

8.3 The Member may nevertheless terminate his/her insurance of the Policy at the end of a one-year period by registered letter sent to the Insurer or his Agent, at least two months before the due date.

ARTICLE 9 - EFFECTIVE DATE OF BENEFITS

9.1 The benefits of this Policy shall enter into effect on the date of application of the Participant and its Successors, as defined in Article 8 above.

9.2 The Insurer shall only pay for expenses incurred from the effective date of the benefits and for the duration of the Cover Period.

ARTICLE 10 - CHANGE OF LEVEL OF BENEFITS

10.1 In the event of a change of the Member's initial Host Country, the Member shall inform the Insurer or his Agent in writing, 15 days before the effective date of change of Country.

10.2 The Member may, during the course of the insurance, change the level of coverage initially chosen. He/she shall fulfil the following cumulative conditions:

- have already adhered to the Policy for at least one year;
- provide a new Medical Questionnaire less than one month old, duly completed and signed by him/her.

The Member may change the level of coverage at the next annual renewal by notifying the Insurer or its Agent by registered letter with acknowledgement of receipt, at least two months before the renewal date.

The rate for the new level of coverage is applicable to him on the first day of the calendar month following the date of receipt of the letter expressly mentioning the agreement of the Insurer or its Agent to subscribe to the new level of coverage desired.

ARTICLE 11 - TERMINATION AND CANCELLATION OF POLICY

The insurance of an Insured Person shall terminate on the earliest of the following:

- The date this Policy is terminated;
- The date that any premium required or due on the part of the Insured Person remains unpaid;
- The date that the Insured Person reaches age seventy-one (79);
- The date the foreign assignment or employment terminates.
- The date the insured Dependent ceases to be an eligible Dependent as defined in this Policy.
- Non-payment of premium will result in policy cancellation with no claims liabilities

Termination of the insurance of any Insured Person either because of termination of employment or termination of this Policy will not prejudice consideration of any claim that may have occurred prior to such termination.

The Policy can be cancelled by either party giving 30 days notice in writing to Dubai Insurance co. (P.S.C).
In the event of cancellation by the Policyholder, Dubai Insurance co. (P.S.C) will retain premium as per the following short term premium rates.

- 25% of the annual premium for the first month or part thereof.
- 12.5% of the annual premium for each subsequent month or part thereof.

Dubai insurance co. (P.S.C) have the right to cancel the policy with immediate effect if;
- Premium in not paid as per the premium payment agreed terms
- Misrepresentation of info
- Non disclosure of material facts.

In the event of cancellation by the company, Dubai insurance co. (P.S.C) will refund premium for the remaining policy period on prorate premium basis.

ARTICLE 12 - CALCULATION OF PREMIUMS

12.1 Healthcare premiums

12.1.1 The amount of premiums shall be determined on the basis defined in the Schedule of Insurance.

12.1.2 In the event of a temporary coverage or the departure of an Insured during the year, the amount of the contribution shall be adjusted and the contribution relating to the last quarter of coverage due for the entire quarter.

12.1.3 The pricing conditions shall be established according to the levels of compulsory and optional benefits chosen, the age bracket and the family situation of the Member for Hospitalisation, Medical, Optical and Dental expenses.

12.1.4 Age shall be determined by the difference in years between the current year and the year of birth. The change in age shall be taken into account at the time of the annual renewal of insurance.

12.1.5 The Insurer reserves the right to adjust the amount of the premiums on 1st January of each year, in accordance with changes in the medical cost of health expenses in each country, changes in local legislation, changes in the AED/EUR exchange rate and all of the technical results of this Policy signed with the Insurer.
In the event of a change in the rate, the new amount of the rate shall apply to the renewal of the insurance. The Insurer or its Agent shall notify the Policyholder or its Agent at least two months prior to expiry date of this Policy. The Policyholder or his Agent shall notify the Member in writing at least thirty days prior to expiry date of the coverage.

12.2 Pension premiums

12.2.1 The premiums to the Pension Coverage shall be calculated, unless otherwise provided in the Schedule of Insurance, according to the age of the Member, the amount of the Death Benefit chosen and of the Deductible Period and the amount of the daily allowance when the Member chooses the TTI - Permanent Disability option.

12.2.2 The Insurer shall reserve the right to adjust the amount of premiums on January 1st of each year, in accordance with the technical results of this Policy signed with the Insurer. In the event of a change in the rate, the new rate amount shall apply to the renewal of the coverage. The Insurer or its Agent shall notify the Policyholder or its Agent at least two months before the renewal date of this Policy. The Policyholder or his Agent shall notify the Member in writing at thirty days prior to expiry date of the coverage.

ARTICLE 13 - PAYMENT OF PREMIUMS BY THE MEMBER

13.1 The payment of premiums shall be incumbent on the Member, who shall be solely liable for their payment to the Policyholder or to his/her Agent. Premiums shall be payable in advance in Arab Emirates Dirham (AED) only, by current-dated cheques, post-dated cheques or bank transfer depending on the division and the terms and conditions mentioned on the Application Form. **Bank charges shall remain the sole liability of the Member.**

In the absence of payment of a premium or a fraction of a premium within 10 days of its due date, the benefit shall be suspended thirty days after the formal notice to pay has remained unsuccessful, which the Insurer or its Agent shall send to the Member by registered letter with acknowledgement of receipt (indicating the due date of the termination, if applicable).
Once this 30-day deadline has expired, the coverage shall be terminated without further formality 10 days later.

13.2 Any present and future taxes, charges and levies applicable either to premiums or to amounts due or payable shall be borne by the Member.

13.3 Premiums shall be due until the end date of coverage. After termination of the coverage, any payment of premiums, whether total or partial, shall only constitute a regularisation of the Member's client account and may not,
unless the Member expressly requests it by letter from the Insurer or its Agent, constitute a tacit reinstatement of the benefits provided in the Policy.

ARTICLE 14 - DECLARATIONS AND NOTIFICATIONS

14.1 Declarations and notifications of the Policyholder

14.1.1 Declarations and notifications shall only be effective if they have been received in writing by the Insurer or its Agent.

14.1.2 The Policyholder shall be required to notify the Insurer or its Agent of any change in its corporate name or address, and in its sectors or places of activity. Failing this, all notifications from the Insurer or his Agent shall be validly made to him/her under the last company name or at the last company address of which they were aware.

14.2 Declarations and Notifications of the Insured

14.2.1 In accordance with local regulation coverage (Member) of this Policy shall be null and void in the event of withholding or intentional misrepresentation by the Member, when this withholding or misrepresentation changes the purpose of the risk or reduces its opinion for the Insurer, even if the omitted or misrepresented risk would have been without influence on the loss.

14.2.2 In the event of withholding or intentional false declaration by the Member, the premiums paid shall remain the property of the Insurer by way of damages.

14.2.3 In accordance with local regulation:

- **an unintentional omission or inaccurate declaration by the Member before the occurrence of the loss shall entail either maintenance of coverage or registration in return for an increase in the contribution or termination of coverage or registration in the Policy, 10 days after notification by the Insurer by registered letter;**

- **omission or unintentional misrepresentation of the Member after the occurrence of the claim shall entail a reduction of the indemnity in proportion to the amount of premiums paid compared to the amount of premiums which would have been due if the risks had been properly declared.**

ARTICLE 15 - DOCUMENTS TO BE PROVIDED BY THE POLICYHOLDER

The Policyholder or his/her Agent shall provide the Insurer or his Agent with:

15.1 On subscription and then at the time of each annual renewal of the Policy:

A statement of the Insured parties, including, for each of them:

- Surname, first name(s), date of birth, sex;
- Family status (Member, spouse, dependent child);
- Host Country;
- Effective date indicated on the Insurance Certificate and end date of coverage;
- The chosen benefits;
- The corresponding contribution.

15.2 During the year, as soon as possible, and at the latest by the end of the calendar month in which the event occurred:

- The Application Form and the Medical Questionnaire completed and signed for all new Insured Parties, which is less than one month old. Each Medical Questionnaire shall be forwarded in a confidential envelope to the Insurer's Medical Adviser or to its Agent;
- A statement by the Members who have decided to terminate their Policy and of the persons who have lost their status as Insured;
- Any change in application (such as a change in the Insured Party's address or family status).

ARTICLE 16 - COMMITMENTS OF THE POLICYHOLDER

16.1 The Policyholder or his/her Agent undertakes to pay the premiums when due to the Insurer or to its Agent.

In the absence of payment of a premium or a fraction of a premium within 10 days of its due date, the benefit shall be suspended thirty days after a formal notice to pay has remained unsuccessful, which the Insurer or its Agent sends to the Policyholder or its Agent by registered letter with acknowledgement of receipt (indicating the due date of the termination, if applicable).
Once this 30-day period has lapsed, coverage shall be terminated without further formality 10 days later.

Premiums shall be due until the end of the Policy. After termination of the Policy, any payment of a contribution, whether total or partial, shall only constitute a regularisation of the Policyholder's customer account and shall not, unless expressly requested by the Policyholder and accepted by letter from the Insurer, constitute a tacit reinstatement of the benefits provided in the Policy.

16.2 The Policyholder or his Agent undertakes to:

- submit to each Member the Information Notice pre-established by the Insurer for this purpose;

- inform the Participants in writing of any changes to their rights and obligations, at least three months before their scheduled effective date.

Proof of the forwarding of the Information Notice to Members and of information relating to changes in their rights and obligations shall be the responsibility of the Policyholder or his Agent. The Member may terminate his or her coverage as a result of these changes.

ARTICLE 17 - WAIVER OF INSURANCE

I, the undersigned party *(Surname and First Name(s) of the Member)*, resident at *(main residence)*, hereby declare that I waive my insurance of EmiratExpat Santé CFE / ASM Policy No. A XXXX *(insured number)*, which I signed on *(DD/MM/YYYYY)*.

(If premiums have been collected) Please reimburse me for the premiums paid, minus the attributable contribution *pro rata* to the benefit period.

(In the event of distance marketing) I undertake, for my part, to reimburse the amount of the services which may have been paid to me.

Drawn up in ……., on.....Signature of the Member

Consequences in the event of exercise of the right of waiver:
The exercise of the right of waiver entails the termination of insurance of the Policy starting from the date of receipt of the registered letter. The latter party may nevertheless no longer exercise this right of waiver a soon as the Member becomes aware of a claim involving the benefit of the Policy.

In the event of a waiver, the Insurer shall refund the premiums within thirty days of the date of termination, minus the amount corresponding to the period during which the coverage was effective.
If the Member asserts his/her right of waiver when a loss event enforcing the coverage benefit and of which he/she was not aware has occurred during the waiver period then the entire premium shall be payable to the Insurer.

In the event of exercise of the right of waiver and sale or provision of services at a distance:

In return for the immediate and full execution of coverage before the expiry of this withdrawal period, the contribution due from the Member shall be equal to the proportion of the annual contribution for the period between the effective date provided at the time of conclusion of the insurance and the possible date of receipt of the withdrawal.
If payments have been made, the Member undertakes to reimburse the Insurer for the amounts received within 30 days.
If premiums have been collected, the Insurer will refund them within 30 days, minus the premium *pro rata* to the coverage period.

ARTICLE 18 - LEGAL SUBROGATION

Subrogation
Once the Insurance claim has been paid in accordance with the current terms, the Policyholder and Beneficiary subrogates his/her right to the Insurer to pursue any third responsible for any Bodily Injury and transfer to the Insurer every relevant substantial and legal right. Both the Policyholder and the Beneficiary shall provide the Insurer with every possible assistance should the Insurer exercise the above right of subrogation. Should the Policyholder and the Beneficiary breach this obligation, they shall be responsible for any losses incurred by the Insurer.

Other Insurance
We will not pay for medical treatment charges if there is or may be any other insurance or indemnity that may cover those charges. If the other insurance or indemnity does not cover all medical treatment charges, we will pay the balance subject to the limitations of this policy.

We have full rights of Subrogation.

ARTICLE 19 - STATUTORY CONDITIONS

The Application, the Policy, any document attached to the Policy when issued, and any amendment to the contract agreed upon in writing after the Policy is issued, constitute the entire contract. Any provision of the Policy which, on its effective date, is in conflict with the statutes of the jurisdiction in which the Policy was issued is hereby amended to conform to the minimum requirements of such statutes.

ARTICLE 20 - EXAMINATION OF CLAIMS - MEDIATION

First contact: the usual contact person for the Policyholder, for his/her Agent and for the Members
In the event of a complaint concerning the Policy, the Policyholder, his/her Agent and the Members are initially invited to contact their usual contact person (commercial intermediary or customer service).

Second contact: the complaints department
If a disagreement persists, the Policyholder, his/her Agent and the Members may contact the Claims Department of MSH International Dubai

As a last resort: the Mediation Department
The Mediation Department intervenes after all avenues with the various services have been exhausted.
Its contact details shall systematically be provided to the Policyholder, his/her Agent and Members by the Claims Department in the event of partial or total refusal to accept the claim.

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DUBAI INSURANCE

TITLE II

SPECIFIC PROVISIONS

HEALTH BENEFITS

ARTICLE 1 – OBJECT OF BENEFITS

The object of the benefit is to reimburse the Insured Parties for all or part of medical, surgical, optical or dental expenses, in accordance with the terms and limitations defined in this Policy.

ARTICLE 2 - GUARANTEED BENEFITS

2.1 The medical, surgical, optical or dental expenses considered are exclusively those listed in article 4 of Title II (Reimbursable Expenses).

2.2 With regard to each Insured, the Reimbursable Expenses for which the starting date of treatment falls between the effective date and the date of termination of insurance/registration relating to this Insured shall provide entitlement to payment, provided that the medical procedures which generated these Reimbursable Expenses have been prescribed and executed by doctors authorised and qualified to practice them, or by Eligible Health Institutions.

2.3 When the reimbursement of reimbursable Expenses is supplementary to the reimbursements of the C.F.E.:

- the reimbursement of Insurer or of its Agent shall be subordinated to that entity, it also being understood that any intervention by one or other of these regimes shall be deducted from the amounts covered by the benefit provided in this Policy, pursuant to article 2.4 below,

- only Reimbursable Expenses for which the starting date of treatment, as shown on the C.F.E. falls between the effective date and the date of termination of insurance related to this Insured Person shall be reimbursable.

2.4 The benefits guaranteed by this Policy shall supplement the benefits of the same nature which could have been paid to any Insured, both by the C.F.E., as well as by any other supplementary coverage from which he/she could benefit, without any Insured being able to receive in full an amount higher than the costs actually incurred (i.e. for all benefits, whether provided by the C.F.E., a complementary scheme, individual or collective pension cover or by this Policy).

ARTICLE 3 - DIRECT ASSUMPTION

3.1 Emergency Hospitalisation

The Insurer or its Agent shall be contacted and informed of the Hospitalisation of the Insured within 48 hours of Hospitalisation, in order to arrange for the direct assumption of the Reimbursable Expenses.

3.2 Hospitalisation

A request for prior agreement shall be sent to the Insurer or to his/her Agent, at least two weeks before the scheduled Hospitalisation date. After the agreement, the Insurer or its Agent shall issue an assumption agreement and the expenses shall be paid directly to the Eligible Health Institution.

The following are excluded from direct assumption outpatient consultations directly relating to hospitalisation (post and pre-hospital) and pre- and post-delivery sessions.

ARTICLE 4 - REIMBURSABLE EXPENSES

Provided they appear in the Benefit Form chosen by the Member, the following expenses shall be reimbursable expenses:

4.1 Hospitalisation

- Medical and surgical hospitalisation;
- Psychiatric hospitalisation;
- Hospitalisation at home;
- Day hospitalisation;
- The daily fixed fee;
- Fees for medical and surgical procedures;
- Any treatment during hospitalisation;
- The following medical facilities during Hospitalisation covered by this Policy: a private room (including the provision of a telephone and a television by the Eligible Health Institution), as well as an accompanying person's bed when the hospitalised child is under 16 years of age;
- Outpatient consultations directly relating to hospitalisation (post- and pre-hospital);
- Land ambulance transport relating to Hospitalisation covered by this Policy;
- Post-operative care and follow-up;
- Rehabilitation session(s) in a rehabilitation centre following hospitalisation.

4.2 Maternity

- Expenses related to childbirth (including surgical childbirth);
- Pre- and post-partum sessions (birth preparation sessions and abdominal rehabilitation sessions after delivery);
- Expenses relating to in vitro fertilisation, for women until their 45th birthday;
- Private room (within the same limits as those of the Hospitalisation).

4.3 Medical expenses

- Consultations and examinations by general practitioners and specialists;
- Consultations and examinations by psychiatrists;
- Consultations with medical auxiliaries: chiropodists, speech therapists, speech therapists, orthoptists, nurses and physiotherapists;
- The costs of "alternative medicines": acupuncture, chiropracty, homeopathy, osteopathy, phytotherapy and traditional Chinese medicine and other practitioners of alternative medicine, when these are officially recognised by the C.F.E. in the Host Country.
- Radiological and medical imaging procedures (MRI, scanner), as well as medical analysis procedures and other medical procedures outside hospitals;
- Pharmaceutical and vaccination costs, provided that the purchase or renewal has been ordered in writing by a doctor, whether these costs are reimbursable by the C.F.E. and, in all cases, that the sale has been made by a qualified pharmacist or by a person legally authorised to execute pharmaceutical commercial transactions;
- A health check-up every five years at an Eligible Health Institution (urine test, diabetes and cholesterol diagnosis, hearing acuity, biometric check-up (height, weight, BMI measurement), visual acuity, resting electrocardiogram, memory test, breath measurement, oral examination, gynaecological examination (breast and cervical cancer research), "hemoccult" test, HIV test);
- Medical devices and prostheses (excluding dental braces and prosthetic devices).

4.4 Optics

- Glasses;
- Frames of the glasses;
- Contact lenses (including “disposable” lenses);
- Refractive surgery.

4.5 Dental

- Care, implants and dental prostheses;
- Orthodontics.

ARTICLE 5 - LIMITATIONS ON REIMBURSABLE EXPENSES

5.1 “Unusual or unreasonable expenses” may form the object of a refusal of coverage or a limitation of the amount of coverage by the Insurer or its Agent. In assessing the “unusual or unreasonable” character of the Reimbursable Expenses and in deciding whether to deny or limit the amount of coverage, the Insurer shall take into account the charges ordinarily applicable for a similar service or benefit, under the best possible conditions in the place, or service, where the benefit was administered.

5.2 Reimbursable expenses incurred in a private Eligible Health Institution shall only be reimbursed if this institution has been duly and previously authorised by the competent authorities of the country.

5.3 The Insurer or its Agent reserves the right to conduct any medical or administrative examination in the event of unusual or unreasonable expenses. It may summon the Insured person for an examination unless this is incompatible with his/her state of health. The transport costs shall be borne by the Insured.

5.4 Expenses for which coverage has been rejected by the Insurer or its Agent shall remain the sole liability of the Insured.

ARTICLE 6 - AMOUNT OF REIMBURSEMENTS

6.1 The reimbursements granted by the Insurer or by its Agent to any Insured Person are defined in the Schedule of Insurance as a supplement to the benefits paid by the C.F.E.

6.2 Refunds shall be paid to the Participant in Arab Emirates Dirham (AED), or in the currency of choice of the latter party, by bank transfer, if he/she resides in a country outside of the United Arab Emirates.

ARTICLE 7 - MAXIMUM COMMITMENT

The maximum amount of the commitment is set according to the level of the Hospitalisation and Medical Expenses benefits which the Member chose.
The benefits of this Policy shall be exercised up to the following amounts per Insured Person and per calendar year of insurance, including benefits paid by the C.F.E.:

- AED 2,000,000 for the Essential level of benefits;
- AED 6,200,000 for the Medium level of benefits;
- AED 8,250,000 for the Optimum level of benefits.

ARTICLE 8 - TERMINATION OF BENEFITS

The Health benefit ceases when the Member's coverage has ceased under the conditions of Article 11 of Title I.
The benefits shall cease when the Member reaches the age of 79.

The coverage of the Beneficiaries shall cease at the same time as that of the Member under the conditions listed above.

ARTICLE 9 - TERRITORIAL SCOPE

9.1 The Geographical Benefit Area is the United Arab Emirates.
9.2 Any exception shall, under penalty of refusal of reimbursement, be subject to the prior agreement of the Insurer or its Agent.
Expenses shall be incurred as a priority in the Member's Host Country or in his/her country of origin. Exceptionally, expenses may be incurred in a country bordering that of hosting if the quality of care is better, subject to the prior agreement of the Insurer or his Agent. Travel expenses shall remain the sole liability of the Member.

In the event of an emergency (Accident or Sudden Illness), Reimbursable Expenses incurred in countries outside of the applicable Geographical Benefit Area shall be covered if incurred during a private or business trip of the Insured of up to 30 days. Travel expenses shall remain the sole liability of the Insured.

ARTICLE 10 - APPLICATION FOR PRIOR AGREEMENT

10.1 The prior agreement of the Insurer or its Agent shall be requested for all expenses listed below:

Hospitalisation and maternity
- An application for prior agreement shall be addressed to the Insurer or to its Agent at least two weeks before the scheduled Hospitalisation date, except in the event of an.

In the event of an emergency: the application for prior agreement shall be sent to the Insurer or to its Agent within 48 hours of entering the Eligible Health Institution (hospital or clinic), mentioning the urgent character of the Hospitalisation.

Exceptionally, this 48-hour period may be extended if the Insurer or its Delegating Authorities certifies that the manifestly urgent situation of the Insured made it impossible to make a request for a prior agreement within the assigned deadlines.

In the absence of a request for prior agreement, the fees shall be reduced or not reimbursed.

For any extension of Hospitalisation beyond 10 consecutive days, the request for a prior agreement shall be renewed every 10 days. It shall be received by the Insurer or its Agent within 48 hours of the end of the said period.
For any transfer of medical or surgical services, a new request for a prior agreement shall be made within 48 hours of the change.

In the event of a change of service during Hospitalisation, the Insured shall renew his/her request for a prior agreement with the Insurer or his Agent.

- For stays at a Rehabilitation Centre, a request for prior agreement shall be addressed to the Insurer or its Agent at least two weeks before the date of Rehabilitation following Hospitalisation.

Medical expenses
- Serial procedures, when their number exceeds 10 per prescription and per Insured (prior agreement shall also be requested in the event of renewal of a prescription for less than 10 procedures, bringing the number of procedures to over 10).

The request for prior agreement shall be accompanied by the prescription of the prescribing physician and shall include the pathology and the foreseeable duration of the treatment.

The Insured shall submit the request for prior agreement completed and signed by the practitioner to the Insurer's Medical Adviser or that of his Agent, in a confidential envelope, at least ten days before the start of the performance of the medical procedures.

Dental

- Braces, implants and dental prostheses (including temporary crowns);
- Orthodontics.

At least 10 days before treatment, a request for prior understanding, completed and signed by the practitioner, shall be sent to the Insurer or to its Agent. Depending on the acts for which a prior agreement is requested, a panoramic x-ray may be required.

Optics

- Refractive surgery.

10.2 In the event of failure to observe the prior understanding procedure, reimbursement of benefits shall be refused.

10.3 Reimbursable benefits which have been rejected by the Insurer or its Agent shall remain the sole liability of the Insured.

ARTICLE 11 - PAYMENT OF SERVICES

11.1 To obtain payment of services, the Insured shall forward to the Insurer or to its Agent the following original supporting documents:

- The medical prescription;
- The detailed and paid invoice, as well as the fees of any practitioner and of any Eligible Health Institution;
- Receipts issued by pharmacies with the associated prescription;
- The agreement of the Insurer or its Agent for care subject to a request for prior agreement (article 10 of Title II).

11.2 The Insurer or its Agent shall reimburse the benefit as soon as it is in possession of all of the information indicated above.

11.3 Claims for reimbursement shall be submitted to the Insurer or its Agent, under penalty of forfeiture, within 90 days of the date on which health care began.

11.4 Payment shall be made to the order of the Member or to an agent expressly appointed by the Member.

ARTICLE 12 - EXCLUDED RISKS

Although we cover most medically necessary treatment, expenses incurred for the following treatments, medical conditions and procedures are not covered under the policy unless confirmed otherwise in the Table of Benefits or in any written policy endorsement.

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DUBAI INSURANCE

EXCLUSIONS: DHA
Applying to residents of the Emirate of Dubai / Northern Emirates policies

This Insurance Policy is intended to provide cover for expenses incurred for Medical Treatment of Medical Conditions or Bodily Injuries which, in the opinion of both the treating physician are Medically Necessary and which are covered under the Terms and Conditions of the Insurance Policy.

This Insurance Policy does not cover, amongst other things, expenses arising directly or indirectly from the following:

Excluded healthcare services except in cases of medical emergencies

1. **Diagnostic and treatment services for dental and gum treatments**
2. **Hearing and vision aids, and vision correction by surgeries and laser**

Excluded (non-basic) healthcare services

1. Healthcare Services which are not medically necessary
2. All expenses relating to dental treatment, dental prostheses, and orthodontic treatments.
3. Care for the sake of travelling.
4. Custodial care including
(1) Non-medical treatment services;
(2) Health-related services which do not seek to improve or which do not result in a change in the medical condition of the patient.
5. Services that do not require continuous administration by specialized medical personnel.
6. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies).
7. All cosmetic healthcare services and services associated with replacement of an existing breast implant. Cosmetic operations which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body and breast reconstruction following a mastectomy for cancer are covered.
8. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
9. Medical services utilized for the sake of research, medically non-approved experiments, investigations, and pharmacological weight reduction regimens.
10. Healthcare Services that are not performed by Authorized Healthcare Service Providers.
11. Healthcare services and associated expenses for the treatment of alopecia, baldness, hair falling, dandruff or wigs.
12. Health services and supplies for smoking cessation programs and the treatment of nicotine addiction.
13. Treatment and services for contraception
14. Treatment and services for sex transformation, sterilization or intended to correct a state of sterility or infertility or sexual dysfunction. Sterilization is allowed only if medically indicated and if allowed under the Law.
15. External prosthetic devices and medical equipment.
16. Treatments and services arising as a result of professional sports activities, including but not limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any other professional sports activities.
17. Growth hormone therapy unless medically necessary.
18. Costs associated with hearing tests, prosthetic devices or hearing and vision aids.
19. Mental Health diseases, both outpatient and in-patient treatments, unless it is an emergency condition.
20. Patient treatment supplies (including for example: elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments,) excluding supplies required as a result of Healthcare Services rendered during a Medical Emergency.

21. Allergy testing and desensitization (except testing for allergy towards medications and supplies used in treatment); any physical, psychiatric or psychological examinations or investigations during these examinations.
22. Services rendered by any medical provider who is a relative of the patient for example the Insured person himself or first-degree relatives.
23. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during in-patient treatment.
24. Healthcare services for adjustment of spinal subluxation.
25. Healthcare services and treatments by acupuncture; acupressure, hypnotism, massage therapy, aromatherapy, ozone therapy, homeopathic treatments, and all forms of treatment by alternative medicine.
26. All healthcare services & treatments for in-vitro fertilization (IVF), embryo transfer; ovum and sperms transfer.
27. Elective diagnostic services and medical treatment for correction of vision
28. Nasal septum deviation and nasal concha resection.
29. All chronic conditions requiring haemodialysis or peritoneal dialysis, and related investigations, treatments or procedures.
30. Healthcare services, investigations and treatments related to viral hepatitis and associated complications, except for the treatment and services related to Hepatitis A and C.
31. Any services related to birth defects, congenital diseases and deformities unless if left untreated will develop into an emergency.
32. Healthcare services for senile dementia and Alzheimer's disease.
33. Air or terrestrial medical evacuation and unauthorized transportation services.
34. Inpatient treatment received without prior approval from the insurance company including cases of medical emergency that were not notified within 24 hours from the date of admission where possible.
35. Any inpatient treatment, investigations or other procedures, which can be carried out on outpatient basis without jeopardizing the Insured Person's health.
36. Any investigations or health services conducted for non-medical purposes such as investigations related to employment, travel, licensing or insurance purposes.
37. All supplies which are not considered as medical treatments including but not limited to: mouthwash, toothpaste, lozenges, antiseptics, , food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions); and all equipment not primarily intended to improve a medical condition or injury, including but not limited to: air conditioners or air purifying systems, arch supports, exercise equipment and sanitary supplies.
38. More than one consultation or follow up with a medical specialist in a single day unless referred by the treating physician.
39. Health services and associated expenses for organ and tissue transplants, irrespective of whether the Insured Person is a donor or a recipient. This exclusion also applies to follow-up treatments and complications unless if left untreated will develop into an emergency.
40. Any expenses related to immunomodulators and immunotherapy unless medically necessary.
41. Any expenses related to the treatment of sleep related disorders.
42. Services and educational programs for people of determination, this also includes disability types such as but not limited to mental, intellectual, developmental, physical and/or psychological disabilities.

Healthcare services outside scope of insurance (In emergency cases as defined by PD 02-2017, the following must be covered until stabilization at minimum)

1. Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.
2. Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type.
3. Healthcare services for injuries and accidents arising from nuclear or chemical contamination.
4. Injuries resulting from natural disasters, including but not limited to: earthquakes, tornados and any other type of natural disaster.
5. Injuries resulting from criminal acts or resisting authority by the Insured Person.
6. Injuries resulting from a road traffic accident.

7. Healthcare services for work related illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulation of Work Relations, its amendments, and applicable laws in this respect.
8. All cases resulting from the use of alcoholic drinks, controlled substances and drugs and hallucinating substances.
9. Any investigation or treatment not prescribed by a doctor.
10. Injuries resulting from attempted suicide or self-inflicted injuries.
11. Diagnosis and treatment services for complications of exempted illnesses.
12. All healthcare services for internationally and/or locally recognized epidemics.
13. Healthcare services for patients suffering from (and related to the diagnosis and treatment of) HIV – AIDS and its Complications and all types of hepatitis except virus A and C hepatitis.

EXCLUSIONS: DOH
Applying to residents of the Emirate of Abu Dhabi /Al Ain Policy only

1. **Healthcare Services, which are not medically necessary**
2. All expenses relating to dental treatment, dental prostheses, and orthodontic treatments.
3. Domiciliary care; private nursing care; care for the sake of travelling.
4. Custodial care includes (1) Non medical treatment services; or (2) Health related services which do not seek to improve or which do not result in a change in the medical condition of the patient.
5. Services which do not require continuous administration by specialized medical personnel.
6. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies)
7. Healthcare Services and associated expenses for replacement of an existing breast implant. Cosmetic operations which improve physical appearance and which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. Breast reconstruction following a mastectomy for cancer is covered.
8. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
9. Medically non-approved experimental, research, investigational healthcare services, treatments, devices and pharmacological regimens.
10. Healthcare Services that are not performed by Authorized Healthcare Service Providers, apart from Healthcare Services rendered in a Medical Emergency.
11. Healthcare services, treatments & associated expenses for alopecia, baldness, hair falling, dandruff or wigs.
12. Supplies, Treatment and services for smoking cessation programs and the treatment of nicotine addiction.
13. Non-medically necessary Amniocentesis.
14. Treatment, services and surgeries for sex transformation, sterility and sterilization
15. Treatment and services for contraception
16. Treatment and services related to fertility / sterility (treatment including varicocele / polycystic ovary / ovarian cyst / hormonal disturbances / sexual dysfunction).
17. Prosthetic devices and consumed medical equipments, unless approved by the insurance company
18. Treatments and services arising as a result of hazardous activities, including but not limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any professional sports activities
19. Growth hormone therapy
20. Costs associated with hearing tests, vision corrections, prosthetic devices or hearing and vision aids.
21. Mental Health diseases, in-patient and out-patient treatments, unless the condition is a transient mental disorder or an acute reaction to stress.
22. Patient treatment supplies (including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments, excluding such supplies required as a result of Healthcare Services rendered during a Medical Emergency).
23. Preventive services, including vaccinations, immunizations, allergy testing and desensitization; any physical, psychiatric or psychological examinations or testing during these examinations.

24. Services rendered by any medical provider relevant of a patient for example the Insured person and the Insured member's family, including spouse, brother, sister, parent or child.
25. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during treatment.
26. Healthcare services for adjustment of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, by any means, except treatment of fractures and dislocations of the extremities.
27. Healthcare services and treatments) by acupuncture; acupressure, hypnotism, rolfing, massage therapy, aromatherapy, homeopathic treatments, and all forms of treatment by alternative medicine.
28. All Healthcare services & Treatments for in-vitro fertilization (IVF), embryo transport; ovum and male sperms transport
29. Elective diagnostic services and medical treatment for correction of vision.
30. Nasal septum deviation and nasal concha resection.
31. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related test/treatment or procedure.
32. Treatments and services related to viral hepatitis and associated complications, except for treatment and services related to Hepatitis A.
33. Birth defects, Congenital diseases for newborn &/or Deformities unless life-threatening.
34. Healthcare services for Senile dementia and Alzheimer's disease.
35. Air or Terrestrial Medical evacuation except for Emergency cases or unauthorized transportation services.
36. Circumcision healthcare services.
37. Inpatient treatment received without prior approval from the insurance company including cases of Medical Emergency which were not notified within 24 hours from the date of admission.
38. Any inpatient treatment, tests and other procedures, which can be carried out on outpatient basis without jeopardizing the Insured Person's health.
39. Any test or treatment, for purpose other than medical such as tests related for employment, travel, licensing or insurance purposes.
40. All supplies which are not considered as medical treatments including but not limited to: mouthwash, toothpaste, lozenges, antiseptics, milk formulas, food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions) and all equipment not primarily intended to improve a medical condition or injury, including but not limited to air conditioners or air purifying systems, arch supports, convenience items / options, exercise equipment and sanitary supplies.
41. More than one consultation or follow up with a medical specialist in a single day unless referred by a physician.
42. Health services and associated expenses for organ and tissue transplants, irrespective of whether the Insured Person is a donor or recipient.
43. Services and educational program for handicaps.

Healthcare Services outside the Scope of Health Insurance

1. **Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.**
2. **Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type.**
3. **Healthcare services for injuries and accidents arising from nuclear or chemical contamination.**
4. **Injuries resulting from natural disasters (including but not limited to) earthquakes, tornados and any other type of natural disaster**
5. **Injuries resulting from criminal acts or resisting authority by the Insured Person.**
6. **Healthcare services for patients suffering from AIDS and its complications.**
7. **Healthcare services for work illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulation of Work Relations, as amended, and applicable laws in this respect.**
8. **All cases resulting from the use of alcohol, drugs and hallucinatory substances.**
9. **Any test or treatment not prescribed by a doctor.**
10. **Injuries resulting from attempted suicide or self-inflicted injuries.**
11. **Diagnosis and treatment services for complications of exempted illnesses.**
12. **All healthcare services for internationally and locally recognised epidemics.**
13. **Venereal sexually transmitted diseases. A list with respect thereto will be set out by the General Authority of Health Services.**

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DUBAI INSURANCE

TITLE III

SPECIFIC PROVISIONS

PENSION BENEFITS

SECTION I - DEATH

ARTICLE 1 - OBJECT OF BENEFITS

1 The object of benefits is to pay the Death benefit to the designated Beneficiary/Beneficiaries in the event of the Member's death, regardless of cause.

The amount of Death benefit which the Member may choose is presented in the Schedule of Insurance of this Policy.

ARTICLE 2 - BENEFICIARIES OF BENEFITS

2.1 The Member shall designate the Beneficiary/Beneficiaries in his/her Application Form. This designation may be modified at any time, as long as the Beneficiary/Beneficiaries have not accepted the benefit of the capital under the conditions of Insurance Code.
In all cases, the Member shall send the Insurer a registered letter dated and signed informing him of this new designation. **Any designation or change of designation not brought to the Insurer's attention shall be unenforceable against it.**

2.2 In the absence of a Beneficiary designated in the Application Form, or if this designation is no longer valid, the benefit of the capital is allocated to the legal heirs:

2.3 In order to avoid any risk of homonymy and to facilitate the search for the designated Beneficiary/Beneficiaries, the Member shall indicate, for each Beneficiary, all details allowing his exact identification, in particular his/her surname and first name(s), date and place of birth. In the event of multiple Beneficiaries, he/she must also ensure that the percentage of capital is allocated among them.
The Beneficiaries' entitlement to the guaranteed capital sum is subject to their existence on the second day after the day of the Member's death.

ARTICLE 3 - DECLARATION OF LOSS EVENT - PAYMENT OF INSURED CAPITAL

3.1 The Death for any reason of a Member shall be declared to the Insurer in writing, within one month of his death, by the Beneficiary/Beneficiaries or by the Policyholder or by its Agent.

3.2 The documentary evidence, translated by the consular services to be submitted to the Insurer for the payment of the Insured capital shall in all cases consist of a photocopy of:

- the **extract from the register of death certificates** on which the death of the Member appears;
- the **medical certificate indicating the cause of death**, failing which the cause of death shall be indicated, as it was brought to the attention of the beneficiaries;
- the updated **family booklet** containing the death of the Member and the usual marginal mentions;
- the Beneficiary's **birth certificate extract**;
- the Beneficiary's **national identity card** on both sides;
- the **notarial certificate** or **certificate of inheritance** issued by the Registry of the District Court;
- the **sworn declaration of non-separation** from his/her spouse or the **PACS agreement** registered at the Registry of the Court of First Instance of the common domicile or the **sworn declaration of cohabitation** of the common-law partner;

- the **declaration of salary** of the employer(s), including the salary elements of the last twelve months subject to contribution, or which would have been of such a nature as to be subject to contribution;
- the Member's **Insurance Certificate.**

3.3 The Insurer reserves the right to request any additional supporting documentation which it judges necessary.

3.4 The Insurer reserves the right to verify that the death of the Member does not result from a risk excluded by article 6 below.

3.5 The Insurer shall pay the Death benefit in Arab Emirates Dirham (AED) to the designated Beneficiary/Beneficiaries within thirty days of the date on which the Insurer receives the supporting documents. **This payment terminates the coverage of the Policy**.

ARTICLE 4 - TERMINATION OF BENEFITS

The Death benefits shall end:

- **when the Insurer has paid the lump sum provided in the event of Death, in advance, in the event of Total and Irreversible Loss of Autonomy or Total and Irreversible Loss of Autonomy following an Accident;**
- **when the Member no longer benefits from the Health Benefit;**
- **at the end of the calendar quarter during which the Member has reached the age set by way of application of legal retirement age**

ARTICLE 5 - COUNTRIES EXCLUDED FROM BENEFITS

5.1 The risk of Death is covered worldwide, with the exception of the following countries: Afghanistan, Angola, Burundi, Burundi, North Korea, India (only the following provinces: Jammu, Kashmir, Punjab, Rajasthan, Gujarat), Iraq, Kosovo, Palestine, Gaza Strip, West Bank, Liberia, Libya, Mali, Mauritania, Nigeria, Pakistan, Democratic Republic of Congo (former Zaire), Rwanda, Sierra Leone, Somalia, Sudan, South Sudan, Syria, Iran, Chad, East Timor and Yemen.

5.2 The Insurer reserves the right to update the list of countries excluded above during the performance of the Policy.

ARTICLE 6 - EXCLUDED RISKS

6.1 The Death benefit shall not apply for one of the following reasons:

- **The suicide of the Insured: no insurance benefit shall be payable if the Insured voluntarily kills him/herself, consciously or unconsciously, during the first year of insurance cover acquired in this Policy possibly under the previous Death Insurance regime with similar benefits subscribed by the Policyholder. In the event of an increase in benefits during the term of the Policy, the risk of suicide, for additional benefits, shall be covered starting from the second year following this increase;**

  - The death of the Member caused by the Beneficiary/Beneficiaries: the benefit ceases to have any effect with regard to the Beneficiary/Beneficiaries when he/she/they has/have voluntarily given or caused the death of the Member. The guaranteed capital shall then be transferred to the next Beneficiary in the order of the designation or of standard clause appearing in the Application Form;
- **The risk of aviation and all air sports: the risks resulting from an Air Navigation Accident shall only be covered if the Insured is on board an aircraft equipped with a valid certificate of airworthiness and is operated by a pilot holding an unexpired licence, with this pilot able to be the Insured him/herself.**

  Matches, bets, races, aerial acrobatics, records, attempts to break records or preparatory tests, as well as acceptance tests, shall be excluded from the benefit.

  The use of the following shall be regarded as aerial navigation:

  - Ultra-Light engine-driven aircraft;

- hang gliders and parachutes, provided that these aircraft comply with existing standards;

- **Risk of war: coverage for risk of war may only be granted under the conditions determined by forthcoming French legislation on life insurance policies in wartime. Wars shall be understood as meaning any armed conflict taking place within French territory or in which France is one of the warring parties;**
- **Serious health risk: the benefit shall cease to be effective when the Insured persons failed to comply, more than 10 days after the publication of the advice by the French consular authorities to its nationals or by the World Health Organisation following a serious health risk (classification as a Public Health Emergency of International Scope USPPI), with any recommendations for repatriation decided by the World Health Organisation.**

This exclusion shall not be enforceable in cases in which the competent local authorities restrict or prohibit all travel.

SECTION II - TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY

ARTICLE 1 - OBJECT OF BENEFITS

1.1 In the event of a Total and Irreversible Loss of Autonomy (TILA), the Insurer shall pay the Member, in advance, the sum insured in the event of Death (article 1.1, Section I of Title III).

1.2 In all cases, the Member shall be regarded as having TILA status when:

- he/she is definitively found incapable of engaging in any occupation or work likely to provide him/her with a gain or profit;
- he/she is obliged to draw on the assistance of a third person for performing ordinary acts of daily life;
- and it is established that his/her condition, which has a definitive character, is not susceptible to any improvement.

ARTICLE 2 - DECLARATION OF THE LOSS EVENT - PAYMENT OF THE INSURED CAPITAL

2.1 The status of the TILA must be reported to the Insurer by the Member. **The declaration must be made in writing, under penalty of forfeiture, within three months, except in the event of unforeseen circumstances or force majeure, from the day on which the Member has been recognised as a TILA in accordance with Article 1 above.**

2.2 Proof of the status of the TILA shall be the responsibility of the Participant. The supporting documents, translated by the consular services, to be submitted to the Insurer are, in all cases:

- the Insurance Certificate;
- a detailed medical certificate, notably specifying the nature of the disability and the date of medical confirmation of the occurrence of the claim causing the disability; this certificate shall also certify that the disability meets the conditions defined in Article 1 above and that it is not subject to any improvement.

In addition, if the scheme subscribed by the Member is in addition to a basic social protection scheme (French Social Security type):

- notification of the decision of this entity, attributing the allowance for assistance from a third party.

The Insurer or its Agent may request any additional supporting documents which it deems necessary.

2.3 The Insurer's Medical Officer reserves the right to verify in the meantime that the PTIA or the PTIAA does not result from an excluded risk (Article 6 below) and to submit the Member to a medical examination at his own expense.

2.4 As soon as the Medical Adviser has acknowledged that the Member's TILA status does not constitute an excluded risk, and at the earliest six months after the date of recognition of the TILA status, the Insurer shall pay in advance, in Arab Emirats Dirham (AED), the Death benefit as defined in articles 1.1 and 1.2 above.

ARTICLE 3 - TERMINATION OF BENEFITS

The TILA coverage shall end:

- **when the Insurer has paid the Death benefit in advance in the event of a TILA to the Member;**
- **when the Member no longer benefits from the Health Benefit;**
- **at the end of the calendar quarter during which the Member has reached the legal retirement age at the full rate in France.**

ARTICLE 4 - COUNTRIES EXCLUDED FROM BENEFITS

4.1 TILA risk is covered worldwide, with the exception of the following countries: Afghanistan, Angola, Burundi, Burundi, North Korea, India (only the following provinces: Jammu, Kashmir, Punjab, Rajasthan, Gujarat), Iraq, Kosovo, West Bank, Gaza Strip, West Bank, Liberia, Libya, Mali, Mauritania, Nigeria, Pakistan, Democratic Republic of Congo (former Zaire), Rwanda, Sierra Leone, Somalia, Sudan, South Sudan, Syria, Iran, Chad, East Timor and Yemen.

4.2 The Insurer reserves the right to update the list of countries excluded above during the performance of the Contract.

ARTICLE 5 - EXCLUDED RISKS

Exclusions from the Total and Irreversible Loss of Autonomy (TILA) benefit

- **The excluded risks are those provided in the event of Death in Article 6.1 Section I of Title III;**
- **Disabilities caused voluntarily or intentionally, consciously or unconsciously, by the insured person (suicide attempt, injuries and mutilations) as well as disabilities caused by an accident at work or an occupational disease.**

SECTION III - TOTAL TEMPORARY INCAPACITY FOR WORK - PERMANENT DISABILITY

ARTICLE 1 - OBJECT OF BENEFITS

1.1 Total Temporary Work Incapacity

1.1.1 In the event of the Member's Total Temporary Incapacity for Work (TTI), the Insurer shall pay him/her a daily indemnity at the end of a Deductible Period, in addition to the benefits of the C.F.E.

1.1.2 The Member shall choose the Deductible Period on the day of his/her insurance in his/her Application Form. The Deductible Period which may be chosen by the Member, among those offered, is detailed in the Schedule of Insurance of this Policy. Periods of resumption of part-time therapeutic work compensated by the C.F.E shall be taken into account for the calculation of the Deductible Period.
The Member shall also choose the amount of the daily allowance, in accordance with paragraph 2.1 of article 2, Section III.

1.1.3 The Member shall be considered to be in a state of TTI when, on account of an Accident or illness, his/her state of health prevents him/her from working. The Member shall also receive a daily allowance from this organisation for this work stoppage.

1.2 Permanent Disability

1.2.1 In the event of the Member's partial or total Permanent Disability, the Insurer shall pay him a disability pension in addition to the benefits of the C.F.E.

1.2.2 The annual amount of the full disability pension corresponds to the amount of the daily indemnities chosen by the Member, multiplied by 360. It shall serve as a basis for calculating the disability pension in accordance with paragraph 2.2 of article 2, Section III.

1.2.3 The Member shall be considered to be partially or totally permanently disabled when, as a result of an illness or Accident which has caused the Insurer to pay daily benefits, the Insurer is unable to exercise all or part of his/her professional activity and simultaneously, after consolidating his/her state of health, suffers from functional incapacity and professional incapacity:

- **Functional incapacity** is determined according to the nature of the disability, general condition, age, physical and intellectual faculties of the Member. It is established according to the functional scale indicative of ordinary law disabilities;
- **Professional incapacity** is assessed according to the rate and nature of the functional incapacity with regard to the profession exercised, the conditions of normal practice, the remaining possibilities of practice, the possibilities of reclassification to a socially equivalent profession and the possibilities of re-education.

The nature and degree of disability shall be determined by the Medical Officer of the Insurer or his/her Agent.

The rates of functional and occupational disability so defined and the disability rate "T" shall be determined according to the following table:

Rate of professional incapacity	**Rate of functional incapacity**								
	20	**30**	**40**	**50**	**60**	**70**	**80**	**90**	**100**
10				29.24	33.02	36.59	40.00	43.27	46.42
20			31.75	36.94	41.60	46.10	50.40	54.51	58.48
30		30.00	36.34	42.17	47.02	52.78	57.69	62.40	66.94
40	25.20	33.02	40.00	46.42	52.42	58.09	63.50	68.68	73.68
50	27.14	35.57	43.09	50.00	56.46	62.57	68.40	73.99	79.37
60	28.85	37.80	45.79	53.13	60.00	66.49	72.69	78.62	84.34
70	30.37	39.79	48.20	55.93	63.16	70.00	76.52	82.79	89.79
80	31.75	41.60	50.40	58.48	66.04	73.19	80.00	86.54	92.83
90	33.02	43.27	52.42	60.82	68.68	76.12	83.20	90.00	96.55
100	34.20	44.81	54.29	63.00	71.14	78.84	86.18	93.22	100.00

The Member shall also have been recognised as being in a state of Partial or Total Permanent Disability by the C.F.E.

ARTICLE 2 - AMOUNT OF PAYMENTS

2.1 The daily allowance paid in the event of the Member's TTI shall be shown on the Member's Insurance Certificate. The amount shall be chosen by the Participant in accordance with the rules defined in the Schedule of Insurance.

2.2 The annual amount of the full disability pension in the event of partial or total Permanent Disability is equal to 360 times the amount of the daily allowance chosen pursuant to paragraph 2.1 above. The amount of the disability pension paid is determined on the basis of this full disability pension and the degree of disability "T", as defined in paragraph 1.2.3 of article 1 of Title IV:

- if the disability rate "T" is greater than or equal to 66%, the disability pension paid shall be equal to the disability pension taken out;
- if the disability rate "T" is between 34% and 65%, the disability pension paid shall be equal to the product of the disability pension taken out and the ratio between "T" and 66%;
- if the degree of disability "T" is less than or equal to 33%, no benefit shall be payable by the Insurer.

2.3 The daily allowance and the disability pension provided in this Policy are limited so that the total amount of benefits received by the Member (French Social Security, C.F.E., other basic scheme, other supplementary insurance, possible salary) shall not exceed 80% of the Member's Base Salary.

ARTICLE 3 - REVALUATION

3.1 Daily allowances and disability pensions in the process of payment shall be revalued while they are in effect, by decision of the Insurer, in accordance with changes in the value of the AGIRC retirement point, from a revaluation fund set up within the framework of the profit and loss account, drawn up annually for all of the insurance policies attached to the portfolio of the "Major Groups of Employees".

3.2 The revaluation shall occur as soon as the first change in the AGIRC pension point occurs following the loss.

3.3 Income in the process of payment shall be revalued within the limit of the revaluation fund mentioned in paragraph 3.1 above.

3.4 In the event of termination of this Policy, the revaluation shall cease, with previously granted revaluations remaining acquired by the Member.

ARTICLE 4 - DECLARATION OF A LOSS EVENT

4.1 Any work stoppage exceeding the Deductible Period and any disability which may provide entitlement to benefits, shall be declared in writing to the Insurer or to its Agent Authority by the Member.

NB: work stoppages or disability, not declared during the 15 days before the end of the Deductible Period, shall be considered to have occurred on the day of their declaration. This provision is intended to limit the loss suffered by the Insurer, which will not have been able to calculate the provisions necessary to cover the risk and to include them in its accounts.

4.2 During the compensation and at the latest within two months of the last payment by the Insurer or its Agent, the Member shall inform it in writing of his/her situation: continuation of time off work (whether or not he/she has the French Social Security or C.F.E. forms), resumption of work or classification as an invalid.

In the absence of this information, compensation for the loss shall automatically be terminated at the end of the two-month period. In the event that new evidence for compensation is submitted after this deadline, the Insurer reserves the right to regard it as a new claim arising on the date on which this evidence of compensation was received by its services.
NB: this provision is intended to limit the loss suffered by the Insurer, which will not have been able to calculate the provisions necessary for covering the risk and including them in its accounts.

4.3 Proof of the TTI status or Permanent Disability shall be the responsibility of the Member.
The original supporting documents, translated and validated by the consular services, to be submitted to the Insurer or its Agent, are as follows:

4.3.1 At the start of payment of benefits:

- the claim form completed in full by it and to which will be attached the compensation forms of the C.F.E. if applicable;
- the medical certificate completed by the Member's doctor, indicating the nature of the pathology, the date of the first symptoms, the likely duration of the incapacity or disability, it being understood that this medical certificate shall be forwarded in a sealed envelope stamped as confidential to the Insurer's Medical Adviser or to its Agent.

4.3.2 During payment of benefits:

- proof of payment of cash benefits by the C.F.E, as and when they are received, as appropriate.

The Insurer reserves the right to request any additional supporting documents which it considers necessary, including documents proving loss of salary.

4.4 The Insurer's consulting doctor reserves the right to verify in the meantime that the disability or incapacity does not result from a risk excluded by Article 9 Section III, and to submit the Member to an expert medical study at its own expense.

4.5 As soon as it has acknowledged that the Member's incapacity or disability does not constitute an excluded risk, the Insurer shall pay him/her:

- in the case of TTI: the amount of the daily allowance defined in paragraph 2.1 of article 2, Section III, on expiry of the subscribed Deductible Period;
- in the event of partial or total Permanent Disability: a disability pension, as defined in paragraph 2.2 of article 2, Section III.

ARTICLE 5 - INSPECTION - EXPERT STUDY

5.1 At any time, the Insurer reserves the right to send one or more doctors whom it has mandated to examine the Member's state of health. This examination shall continue to be conducted even after the termination of this Policy.
In order to conduct this examination, the Insurer reserves the right to summon the Member to French territory, at its own expense.

5.2 Unless justified by a force majeure event, any refusal to submit to this examination shall result in the forfeiture of the benefit and the cessation of payment of benefits in the process of payment.

5.3 When the doctor(s) mandated by the Insurer determines/determine that the Member's state of health does not justify time off work, the Insurer shall cease payment of compensation on the date of the examination.

In the event of a challenge, an expert study shall be conducted. Each of the parties (Insurer and Member) shall appoint a doctor at their own expense. In the event of disagreement between them, they shall appoint a third doctor, half of whose fees will be borne by the Insurer and half by the Member.
If one of the parties fails to appoint an expert or if the doctors representing the parties disagree on the choice of the third doctor, the appointment shall be made by the Presiding Judge of the Regional Court of Paris.

ARTICLE 6 - PAYMENT OF BENEFITS

6.1 The benefits due for the TTI shall be payable monthly, in arrears, until the 1095th day of the TTI at the latest. In any event, the payment of benefits shall cease when the Member pays his/her pension into an old-age insurance scheme within the age limit set pursuant to legal retirement age at full rate. Each payment of daily allowances shall be subject to the submission of a medical certificate mentioning the persistence of the TTI, accompanied by a sworn declaration that professional activity has not been resumed. When the benefits are subscribed as a supplement to the C.F.E., the Member shall produce the basic regime forms certifying the payment of daily allowances by this organisation.

In any event, the payment of daily allowances shall cease on the date on which the Member resumes work.

6.2 Disability pensions are payable quarterly in arrears, at the latest until the Member reaches the age set pursuant to legal retirement age or until the age set pursuant to legal retirement age at full rate if he/she is in employment (in the event of partial Permanent Disability). At least once a year, the disabled Member shall be required to present a medical certificate justifying the persistence of his/her state of disability. When the benefits are subscribed in addition to the French Social

Security or the C.F.E., the Member shall produce the basic scheme forms certifying the payment of a disability pension by this organisation.

ARTICLE 7 - RETURN TO WORK - RELAPSE

7.1 When the Member has begun to receive partial or total TTI or Permanent Disability benefits, any resumption of work, for the same activity as that before the incapacity or disability, for a period of less than two months, shall merely result in a suspension of payment of benefits.

7.2 In this case, and provided that the new work stoppage is due to the same cause, an illness, the payment of daily allowances shall be resumed as soon as the relapse occurs on the same basis, the contractual expiry date of the daily allowances being extended by the duration of the return to work, albeit without causing the age limit for payment of benefits defined in article 6, Section III to be exceeded.

ARTICLE 8 - CESSATION OF BENEFITS

TTI and Permanent Disability benefits shall cease:

- **when the coverages chosen by the Member cease in accordance with Article 11 of Title I;**
- **at the end of the calendar quarter during which the Member has reached the legal retirement age at the full rate in France;**
- **when the Member no longer complies with the conditions of insurance specific to the benefit: when he/she is no longer an employee or when he/she becomes a majority shareholder of the company which employs him.**

ARTICLE 9 - EXCLUDED RISKS

9.1 Work stoppages resulting from the following shall be excluded from the TTI and Permanent Disability benefits:

- **illnesses and accidents which are the voluntary act of the Member or which result from suicide attempts or deliberate mutilations;**
- **acts of civil or foreign war, riot or insurrection, brawls and acts of terrorism, if the Member has taken an active and deliberate part in them. In cases of self-defence, assistance to a person in danger and the performance of a professional duty are guaranteed;**
- **an Accident occurring in the following countries: Afghanistan, Algeria, Angola, Burundi, India (only the following provinces: Jammu, Kashmir, Punjab, Rajasthan, Gujarat), Iraq, West Bank, Gaza Strip, West Bank, Liberia, Libya, Mali, Mauritania, Niger, Nigeria, Pakistan, Central African Republic, Democratic Republic of Congo (ex-Zaire), Rwanda, Somalia, Sudan, South Sudan, Syria, Iran, Chad, East Timor, Yemen. The Insurer reserves the right to update the list of excluded countries during the performance of the Contract;**
- **injuries, injuries resulting from races, matches or bets, with the exception of normal sports competitions in which the Member participates as an amateur;**
- **modification of the structure of the atomic nucleus;**
- **ionising radiation, whatever its origin and intensity, to which the Member is exposed, even intermittently, due to and during his professional activity;**
- **the Member's intoxication. With regard to traffic accidents: when the Member is the driver of the land-based motor vehicle, TTI or Permanent Disability following an accident occurring in the following cases shall be excluded regardless of circumstances:**
  - **in a state of intoxication defined by a blood alcohol level greater than or equal to the legal rate in effect within France at the time of the accident or the legal rate in effect in the country in which the accident took place, if lower;**
  - **under the influence of narcotics;**
- **the use of an Ultra-Light engine-driven aircraft, a flying wing or a parachute;**
- **the practice of the following activities:**
  - **mechanical sports: car, karting, motorcycling;**
  - **mountain sports: rock climbing, mountaineering, ski jumping, spring boarding, bobsleigh;**
  - **other sports: caving, mounted polo, bungee jumping, scuba diving;**

- **sciatica, lumbago, back pain, neck pain (except those of accidental origin);**
- **neuroses, psychasthenia, psychoneurosis and psychoses for the Permanent Disability benefit;**
- **any condition for which the first findings were made prior to the effective date of the Member's coverage under this Policy.**

9.2 Air navigation risks are covered under the same conditions as for the All Causes Death Coverage (Article 5 of Title II).

9.3 No benefits shall be payable during periods of statutory or contractual maternity, paternity[(1)] or unpaid leave, whether the beginning of the work stoppage occurs before or during the leave. However, if, at the end of this leave, the Member's medical condition prevents him/her from returning to work, the benefits are due, in which case the Excess period is deducted from the end of the leave.

[(1)] It is agreed that the legal maternity or paternity leave shall be assessed with reference to that of employees under the French Social Security Basic Regime.

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SCHEDULE OF INSURANCE

ARTICLE 1 – INCEPTION DATE OF THE CONTRACT

The Contract takes effect on **XX/XX/2020**.

ARTICLE 2 – INSURED PERSONS - ADMISSION TO INSURANCE

Members and their Beneficiaries appearing on the Insurance Certificate, aged between 18 and 74 years of age for Essential and Medium plans, and aged between 18 and 70 years of age for Optimum plan on the date of inception, in accordance with the Conditions of Adhesion of Article 6 of Title I, are insured by this Policy.

ARTICLE 3 – BENEFITS

3.1 Geographical Benefit Area

The Geographical Benefit Area is the United Arab Emirates.

3.2 Annual health limit per Insured

The annual reimbursement limit is for Refundable Expenses of the Hospitalization and Medical Expenses benefits. In the event that Optional Dental/Optical Benefits is underwritten, the annual reimbursement limit will apply to the whole.

The benefits of this Contract shall be exercised up to the following amounts by Insured and per calendar year of insurance, including benefits paid by the Caisse des Français de l'Etranger (C.F.E.):

- AED 2,000,000 for the Essential level of benefits;
- AED 6,200,000 for the Medium level of benefits;
- AED 8,250,000 for the Optimum level of benefits.

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3.3 The health benefits for corporates and individuals

	ESSENTIAL	MEDIUM	OPTIMUM
Networks	**MSH COMPREHENSIVE NETWORK**	**MSH PLATINUM NETWORK**	**MSH PLATINUM NETWORK**
Annual ceiling benefits	**AED 2 000 000***	**AED 6.200.000***	**AED 8.250.000***
Pre-existing Conditions	**Covered up to Annual Aggregate Limit**	**Covered up to Annual Aggregate Limit**	**Covered up to Annual Aggregate Limit**
INPATIENT* Mandatory prior agreement			
Medical and surgical hospitalization Day hospitalization Hospitalizations related to dreaded diseases (cancer, AIDS, stroke) Hospitality, medical and surgical fees, all treatment during hospitalization	100% Actual costs*	100 % Actual costs*	100 % Actual costs*
Psychiatric hospitalization	Not covered	Covered limited to 20 days/year	Covered limited to 60 days/year
Rehabilitation following hospitalization (prior agreement) External care or postoperative consultation	100 % Actual costs* max 20 days/year	100% Actual costs* max 30 days/year	100% Actual costs* max 45 days/year
Private room Private room in France	**AED 410/day** **AED 245/day**	**AED 1.630/day** **AED 530/day**	**AED 2.040/day** **AED 1.020/day**
Bed for parent accompanying a child under 18	**AED 165**/day	**AED 265**/day	**AED 410**/day
Day hospitalization Home hospitalization	100% Actual costs*	100% Actual costs*	100% Actual costs*
Ground ambulance transportation related to hospitalization in case of emergency	100% Actual costs*	100 % Actual costs*	100% Actual costs*
MATERNITY Mandatory prior agreement			
Delivery (with or without surgery/complications) in the UAE *Note : Where any condition develops which becomes life threatening to either the mother or the new born, the medically necessary expenses will be covered up to the annual aggregate limit*	1st year : **AED 12.240** with or without surgery From the 2nd year and on: **AED 16.320** without surgery/complications **AED 24.480** with surgery/complications Abu Dhabi/Al Ain policy members Covered up to Annual Limit within the Emirate of Abu Dhabi.	1st year : **AED 20.400** with or without surgery From the 2nd year and on: **AED 32.640** without surgery/complications **AED 48.960** with surgery/complications Abu Dhabi/Al Ain policy members Covered up to Annual Limit within the Emirate of Abu Dhabi.	1st year : **AED 32.640** with or without surgery From the 2nd year and on: **AED 49.960** without surgery/complications **AED 81.600** with surgery/complications Abu Dhabi/Al Ain policy members Covered up to Annual Limit within the Emirate of Abu Dhabi.

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	Outside of Emirate of Abu Dhabi as per above sub limits.	Outside of Emirate of Abu Dhabi as per above sub limits.	Outside of Emirate of Abu Dhabi as per above sub limits.
Delivery (with or without surgery/complications) in France	CFE + **AED 4.080** limited to actual costs	CFE + **AED 12.240** limited to actual costs	CFE + **AED 24.480** limited to actual costs
Out Patient Maternity (Pre and post-natal sessions)	Covered up to Delivery Annual limit	Covered up to Delivery Annual limit	Covered up to Delivery Annual limit
New Born cover - Coverage of a pregnant female is extended by the insurer to provide the same benefits for a new born child of that female for a period up to 30 days from its date of birth. This cover is provided regardless of whether or not the new born is eventually enrolled as a dependent member under the insurer's policy	Cover for 30 Days from birth BCG , Hepatitis B and Neo-Natal Screening test (Phenylketonuria ,Congenital Hypothyroidism ,sickle cell screening, Congenital adrenal hyperplasia)	Cover for 30 Days from birth BCG , Hepatitis B and Neo-Natal Screening test (Phenylketonuria ,Congenital Hypothyroidism ,sickle cell screening, Congenital adrenal hyperplasia)	Cover for 30 Days from birth BCG , Hepatitis B and Neo-Natal Screening test (Phenylketonuria ,Congenital Hypothyroidism ,sickle cell screening, Congenital adrenal hyperplasia)
IVF	Not covered	4 IVF Max **AED 4.080**/IVF/ contract's lifetime	4 IVF Max **AED 6.530**/IVF/ contract's lifetime
OUTPATIENT			
For Direct Billing – Inside MSH Network only			
OP Consultations – For Dubai / Northern Emirates Visa holders and Residents Deductible	100% Actual costs* 20% subject to max up 100 AED on per doctor Visit follow up consultation within 7 days is free for same illness	100% Actual costs* 10% subject to max up 50 AED on per doctor Visit follow up consultation within 7 days is free for same illness	100% Actual costs* 5% subject 10 AED on per doctor Visit follow up consultation within 7 days is free for same illness
OP Consultation – For Abu Dhabi/Al Ain Visa holders and Residents Deductible	100% Actual costs* 40 AED	100% Actual costs* 30 AED	100% Actual costs* 10 AED
MEDICAL AUXILIARIES *Beyond 10 sessions, a prior agreement is mandatory (detailed medical prescription)* Pedicure chiropodists, speech therapy, orthoptist, nursing Physiotherapy	100% Actual costs* Max **AED 4.080**/year/person Max **AED 205**/treatment Dubai: **Max 8 sessions**/year Max **AED 205**/treatment	100% Actual costs* Max **AED 14.280**/year/person Max **AED 490**/treatment Dubai: **Max 15 sessions**/year Max **AED 490**/treatment	100 % Actual costs* Max **AED 24.480**/year/person Max **AED 610**/treatment Dubai: **Max 20 sessions**/year Max **AED 610**/treatment
ALTERNATIV MEDICINE *Beyond 10 sessions, a prior agreement is mandatory (detailed medical prescription)* recognized in the country	100% Actual costs* Max **AED 2.040**/year/person	100% Actual costs* Max **AED 3.060**/year/person	100% Actual costs* Max **AED 6.120**/year/person

Acupuncture, chiropractic, homeopathy, osteopathy, phytotherapy, Chinese medicine			
ANALYSIS / RADIOLOGY / LABORATORY including medical imaging (MRI, scanner) Other medical acts outside hospitals *Test services carried out in the authorized facility assigned to treat the insured person*	100% Actual costs* Beyond **AED 4.080**/year/person, mandatory prior agreement	100% Actual costs* Beyond **AED 6.120**/year/person, mandatory prior agreement	100% Actual costs* Beyond **AED 10.200**/year/person, mandatory prior agreement
PHARMACY: drugs including vaccines reimbursed by the CFE	100% Actual costs*	100% Actual costs*	100% Actual costs*
HEALTH CHECK UP (after 1 year of enrolment and every 5 years) Prevention screening	Not covered Max **AED 2.040**/year/person	100% Actual costs* Max **AED 4.150**/person Max **AED 3.265**/year/person	100% Actual costs* Max **AED 8.300**/person Max **AED 6.210**/year/person
PROSTHETICS	100 % Actual costs* Max **AED 815**/prostheses /year and /person Hospitalization related to an accident : **AED 1.630**/prostheses, /year and /person	100 % Actual costs* Max **AED 2.450**/prostheses /year and /person Hospitalization related to an accident : **AED 4.895**/prostheses, /year and /person	100 % Actual costs* Max **AED 4.080**/prostheses /year and /person Hospitalization related to an accident : **AED 8.160**/prostheses, /year and /person
For Reimbursement only – Outside MSH network			
OP Consultations & visits	100 % Actual costs*	100 % Actual costs*	100 % Actual costs*
General practitioners	Max **AED 205** /treatment	Max **AED 490** /treatment	Max **AED 815** /treatment
Specialists	Max **AED 285** /treatment	Max **AED 610** /treatment	Max **AED 1.020** /treatment
Psychiatric sessions	Not covered	Max 10 sessions/year, **AED 610**/treatment	Max 15 sessions/year, **AED 1.020**/treatment
OPTIONAL ONLY- OPTICAL/DENTAL **You can choose a different level of benefits from the in and outpatient sections**			
	ESSENTIEL	**MEDIUM**	**OPTIMUM**
OPTICAL Simple glasses + frames	100 % Actual costs* Max **AED 815**/year/person	100% Actual costs* Max **AED 1.630**/year/person	100% Actual costs* Max **AED 2.650**/year/person
Complex glasses + frames	100 % Actual costs* Max **AED 1.630**/year/person	100% Actual costs* Max **AED 2.650**/year/person	100% Actual costs* Max **AED 3.470**/year/person
Lenses (including disposable)	**AED 410**/year/person	**AED 1.020**/year/person	**AED 1.430**/year/person
Laser surgery related to myopia	Not covered	100% Actual costs*	100% Actual costs*

		Max **AED 3.265**/year/person	Max **AED 4.080**/year/person
DENTAL **(INDIVIDUALS)** Dental treatments (descaling, extractions, fillings) Prostheses (inlay, onlay, bridge), implants and devices	100% Actual costs* Max 1st year: **AED 2.040**/year/person Max 2nd year and on: **AED 3.265**/year/person From the 2nd year and on, max **AED 6.120**/year/person	100% Actual costs* Max 1st year: **AED 4.080**/year/person Max 2nd year and on: **AED 6.120**/year/person 1st year: **AED 6.120**/person From the 2nd year and on : **AED 12.240**/year/person	100% Actual costs* Max 1st year: **AED 6.120**/year/person Max 2nd year and on: **AED 8.160**/year/person 1st year: **AED 10.200**/person From the 2nd year and on: **AED 16.320**/year/person
DENTAL **(CORPORATES)** Dental treatments (descaling, extractions, fillings) Prostheses (inlay, onlay, bridge), implants and devices	100% Actual costs* Max: **AED 3.265**/year/person Max: **AED 6.120**/year/person	100% Actual costs* Max: **AED 6.120**/year/person Max: **AED 12.240**/year/person	100% Actual costs* Max: **AED 8.160**/year/person Max: **AED 16.320**/year/person
Orthodontic (treatments started before 16 years old)	Not covered	100 % Actual costs* Max **AED 4.080**/year/person Max 3 Years and **AED 12.240**	100% Actual costs* Max **AED 8.160**/year/person Max 3 Years and Max **AED 24.480**

Specific conditions as per DHA and HAAD regulations:

Hepatitis C Virus Screening and treatment - DHA	To be followed as per the guidelines laid out in the Hepatitis C support program
Cancer Screening and treatment- DHA	To be followed as per the guidelines laid out in Cancer support program
Vaccinations (Covered on reimbursed basis) - DHA	Essential vaccinations and inoculations for newborns and children as stipulated in the DHA's policies and its updates in the assigned facilities (currently the same as Federal MOH)
Preventive Services- DHA	Covered Initial Diabetic Screening. Frequency Restricted to : Every 3 years from age 30 High risk individual annually from age 18
Adult Pneumococcal Conjugate Vaccine - DHA	As per DHA Adult Pneumococcal Vaccination guidelines
Healthcare services for illness and injuries as per Federal Law No. 8 of 1980 concerning the Regulation of Work Relations, as amended and applicable laws in this respect. - HAAD	Covered
Preventive Services, Vaccines and immunizations - HAAD	Essential vaccinations and inoculations for newborns and children as stipulated by HAAD.
	Diabetic Screening: Every 3 years from age 30
	High risk individual annually from age 18

3.4 Policy for individuals

3.4.1 Death / Total and Irreversible Loss of Autonomy

Premium per band of AED 82 000

Death / Total and Irreversible Loss of Autonomy capital to be chosen per bands of AED 82 000.
Limited to AED 1 224 000 per employee insured.
If the insured is self-employed, the maximum capital is set at AED 408 000.
If the Total Temporary Incapacity for Work / Permanent Disability cover is subscribed, the Death / Total and Irreversible Loss of Autonomy capital must be at least equal to 1000 times the daily allowance amount chosen.

3.4.2 Total Temporary Incapacity for Work / Permanent Disability

Franchise	**30 days**
Age bands	**Daily allowance per band of AED 83**

Subscription only in complement to benefit in case of Death / Total and Irreversible Loss of Autonomy.
Maximum amount of the daily allowance : 996 AED

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