TERMS AND CONDITIONS FOR HEALTH INSURANCE OF THE EXPAT SERIES (ME) PART I

§ 1 SCOPE OF INSURANCE COVER

As far as has not been agreed to the contrary, the following shall apply:

1. The scope of insurance cover provided by this Insurance Contract shall be as setout in the terms and conditions Part I and Part II (tariff) of the Expat series (ME), any statutory or legal requirements and any additional agreements, including the Company Service Agreement and applicable Employee Benefit Guide, that may have been made in writing between the Insurance Company and the Policy Holder and/ or the Insured Individuals.
2. The Insurance Company shall provide cover to Insured Individuals for the cost of treatment of illnesses, sicknesses, accidents and other events covered by this Insurance Contract within the G.C.C. countries or abroad. The Insurance Company shall reimburse Insured Individuals for expenses incurred in connection with their medical treatment and other benefits agreed upon in this Insurance Contract.
3. This Insurance Contract shall cover claims for the cost of medically necessary treatment of Insured Individuals on account of illness or as a result of an accident. The cover for a claim shall be deemed to begin with the commencement of treatment, and shall end when medical findings indicate that there is no further need of treatment.
4. To the extent that Part II (tariff) includes further benefits reflected below, this Insurance Contract shall cover the costs of:
   a) Examination and medically necessary treatment in connection with pregnancy and childbirth
   b) Routine prophylactic examinations as an outpatient
   c) Death

§ 2 SCOPE OF INSURANCE BENEFITS

As far as has not been agreed to the contrary, the following shall apply:

1. The nature and value of the Benefits provided under this Insurance Contract shall be as setout in the terms and conditions for health insurance of the Expat series (ME), Part II (tariff).
2. An Insured Person may choose from among the approved doctors practising, or from among the doctors, dentists, and medical practitioners who are qualified to give treatment in terms of the law that applies to the country of residence covered by the terms of the Insurance Contract.
3. Pharmaceuticals, bandages, medicines, and other medical aids will be covered if they are prescribed by the qualified practitioners mentioned in § 2, section 2. Pharmaceuticals may be obtained from a licensed pharmacy or licensed pharmaceutical product distributor.
4. In circumstances where hospital treatment is immediately necessary, an Insured Person is at liberty to choose a hospital for treatment from among any public and private hospitals provided such hospitals have constant medical supervision, possess sufficient diagnostic equipment, and maintain appropriate clinical records. The tariff may restrict an Insured Person's choice of provider to network lists maintained by the Insurance Company.
5. In circumstances where medically necessary hospital treatment is provided by licensed hospitals that also carry out health resort and/ or sanatorium and/ or convalescent treatment, but which in other respects conform to the conditions of § 2, section 4, Benefits at the agreed rate will only be paid if the Insurance Company has given written consent prior to the commencement of the treatment. In circumstances where the treatment is for tuberculosis, the Benefit payable will be as provided for by the Insurance Contract in respect of hospital treatment in tuberculosis treatment centres and sanatoria.
6. The Insurance Company will pay Benefits to the extent defined by the Insurance Contract in respect of examination and treatment methods and pharmaceuticals that are in accordance with generally accepted medical standards. It will also pay Benefits for methods and pharmaceuticals which have been proved in practice as being equally likely to achieve success provided the Insurance Company has agreed to cover such treatment in advance and subject to the Insurance Company retaining its discretion to reduce the Benefit level to the amount that would have been paid if generally accepted treatment methods or pharmaceuticals had been used.

§ 3 ELIGIBILITY FOR INSURANCE COVER

So far as has not been agreed to the contrary, the following shall apply:

1. Policy Holders may be both natural and legal persons.
2. Only natural persons may be Insured Individuals.
3. Persons who at the inception of the cover are in need of constant care or mentally ill are not covered by this Insurance Policy, even if premiums have been paid for such persons. A person will be deemed to require constant care if he/ she for the most part requires external help to assist him/ her in the performance of the tasks ordinarily required for daily life.

§ 4 CONCLUSION AND DURATION OF THE INSURANCE CONTRACT

So far as has not been agreed to the contrary, the following shall apply:

1. The Company Service Agreement will be concluded in writing between the Insurance Company and the Policy Holder, on the basis of these terms and conditions of insurance.
2. This Insurance Contract will be automatically renewed at the end of each insurance year up to the maximum possible duration as set out in part II (tariff), if not terminated by either party with a notice of termination given two months prior to the end of the insurance year.
3. The Policy Holder shall be obliged to notify Insured Persons of the cancellation of the Company Service Agreement within one month of the delivery of a notice of termination.
4. Notwithstanding the Policy Holder becoming insolvent or having its registration struck from the Commercial Register, the insurance cover for the Insured Persons will remain unaffected, as long as payment of premiums continues.

§ 5 COMMENCEMENT OF INSURANCE COVER

So far as has not been agreed to the contrary, the following shall apply:

1. Insurance cover shall commence from the date stated in the confirmation document (start of insurance cover), provided the premium has been paid and the waiting period has expired.
2. No Benefit will be paid in respect of claims that were occasioned prior to the commencement of the insurance cover.
3. No Benefit will be paid in respect of claims that were occasioned during the waiting period.

§ 6 END OF INSURANCE COVER

1. The period of insurance cover is as defined by the terms of the relevant tariff.
2. Insurance cover for Insured Persons comes to an end, including in respect of claims and/ or treatments for claims that at such time are in the course of being undertaken:
   a) with the end of the Insurance Contract
   b) following the expiry date agreed upon
   c) deregistration from the group of persons insured by the Policy Holder, taking into account the terms of notice and conditions defined in the tariff
   d) the death of the Insured Person; and/ or

§ 7 EXCLUSIONS

So far as has not been agreed to the contrary, the following shall apply:

1. There shall be no obligation to pay a Benefit
   a) on account of such illnesses, including their consequences, or as the consequence of such accidents as are occasioned by active participation in events of war or civil disturbance, rebellion, revolution, violence, or through professional participation in sporting competitions organized by sporting federations and associations or preparatory measures related to these, or such as are recognized as war injuries and are not explicitly included in the insurance cover.
   b) on account of illnesses and accidents willfully self inflicted by the Insured Individual, including their consequences, or on account of treatment for alcoholism, drug or substance abuse and any illness or injury arising directly from such abuse or addiction withdrawal measures including courses of withdrawal treatment.
   c) in consequence of accommodation occasioned by the need for permanent care or custody
   d) for medical conditions or complaints which existed or for which symptoms were apparent or which the Insured Individual was aware of prior to the inception of the insurance cover (pre-existing conditions).
   e) for the treatment of mental or emotional disturbances, or for hypnosis or psychotherapy.
   f) treatment for illnesses and their consequences arising as a result of Insured Individuals not having obtained protective inoculations prescribed by statute in the Insured Individual's country of residence, unless there is a medical justification as to why such protective inoculation could not be carried out. Where such medical justification exists, these are to be proved to the Insurance Company by the submission of a doctor's certificate.
   g) for treatment by doctors, dentists, medical practitioners or in licensed hospitals the invoices for which the Insurance Company has excluded from reimbursement on good grounds, provided the claim occurs after the Insured Individual has been notified of such treatment facility or individual's exclusion. If at the time of the notification a claim is pending, no obligation to pay the Benefit shall exist for expenses incurred after the expiry of three months from the time of notification being given.
   h) in respect of a stay in a spa or health resort, even if this involves a stay in hospital. This exclusion will not apply in circumstances where the Insured individual has his/ her permanent place of residence there or if he/ she during a temporary stay/ visit becomes unable to return home (based on independent medical opinion) as a result of a sickness independent of the purpose of his/ her visit or as a result of an accident that has occurred there. This exclusion shall not apply if and to the extent that the Insurance Company has given written consent to the Benefit being paid before the start of the stay.
   i) for the administration of treatment by spouses, parents, children, or persons living together in an immediate domestic circle. The evidenced costs of materials used in such treatment will however be reimbursed in keeping with the given tariff.
   j) for treatment costs, procedures, and consequences as a result of medical malpractice.
2. Benefits for any treatment, procedure, and/ or service/ supplies etc. shall be considered as per the Usual Customary Reasonable charges (UCR Charges), i.e. if the medical treatment or other measure for which the Benefit has been agreed exceeds that which was medically necessary, or if the remuneration claimed is not proportionate to the ordinary cost of such medical treatment, the Insurance Company may reduce the benefit to a reasonable level.
3. If there is also a claim on third party benefit providers, the Insurance Company shall only be obliged to pay such benefits or expenses which are necessary and which are not claimable from third parties and are a benefit covered by this Insurance Contract.

§ 8 WAITING PERIOD

The waiting periods that shall apply are those as agreed in the relevant Tariff.

§ 9 PAYMENT OF PREMIUMS

So far as has not been agreed to the contrary, the following shall apply:

1. The premium is an annual premium determined by the relevant Tariff and is to be paid in advance following the conclusion of the Insurance Contract.
2. The Tariff may allow for payment of the premium by direct debit or by credit card payment. The premium shall be considered to have been paid when a legally valid authorisation to debit the Policy Holder's account has been issued, provided the premium amount is effectively debited thereafter.

§ 10 PAYMENT OF INSURANCE BENEFITS

1. The Insurance Company shall be obliged to reimburse Benefits only if the original invoices are presented and the required documentary proof is supplied. Such documentation will become the property of the Insurance Company. If the original documentation has been presented to another Insurance Company for reimbursement, duplicates of the invoices will be considered sufficient, provided that the other Insurance Company has made a note on the document of the benefit it paid.
2. All receipts must contain the name of the professional treating the patient, the first name, surname and date of birth of the patient treated, as well as a description of the illness and the dates of treatment. Benefits paid by other insurance companies, or other companies' refusal to pay such benefits, must be indicated on the receipts.
3. Costs that have been incurred in a foreign currency will be converted into United Arab Emirates Dirhams at the exchange rate of the day on which the receipts are received by the Insurance Company.
4. Costs incurred for the payment of a Benefit by means of a banker's draft to a foreign country, or for special forms of fund transfer which have been selected at the request of the insured party, will be deducted from the Benefit paid.
5. Claims for a Benefit cannot be assigned or pledged
6. The Insurance Company shall pay benefits to the party who submits or sends documentary proof detailing the Benefit to be paid, unless the Insurance Company has good reason to doubt the bona fides of the party submitting or sending such documentation.
7. In respect of claims for return transport, a doctor's certificate should be provided confirming the medical necessity of such transport.
8. For claims in connection with conveyance of a body or funeral costs, an official or medical certificate giving the cause of death must be submitted.

§ 11 OBLIGATIONS

1. On request by the Insurance Company, the Insured Individual and the Policy Holder shall supply any information required to establish the facts giving rise to the claim or the Insurance Company's obligation and scope of the obligation to pay a Benefit to the Insurance Company or its nominee.
2. The Insured Individual is obliged to ensure that damages are mitigated and shall refrain from any activities which are prejudicial to the recovery of Benefits paid or which could delay, hinder or prevent the Insured Individual's recovery.

3. The Insured individual and the Policy Holder shall be obliged to authorize the Insurance company to conduct any reasonable investigations into the cause and extent of the obligation to pay a Benefit, and in particular to submit to examination by a doctor/ medical professional appointed by the Insurance Company; to release treating physicians and other insurance companies from their obligations of confidentiality, if required; and in a case of death to submit a death certificate.
4. The Insured Individual and Policy Holder are to inform the Insurance Company without delay of any change of address (domestic residence, place of business or place of commercial operations). Written declarations by the Insurance Company sent by registered letter to the last known address of the Insured Individual and/ or Policy Holder shall be considered as having been effectively delivered.
5. In so far as in the given country of residence particular stipulations, proceedings or legal regulations apply to the processing of claims, these may be incorporated by the Insurance Company with written notice to the Insured person or the policy holder so as to form an integral part of these terms and conditions of insurance.
6. In circumstances of pregnancy the Insurance Company is to be informed within four weeks of the existence of the pregnancy having been established, unless otherwise provided for in terms of the relevant tariff.
7. The Insurance Company is to be notified of any hospital treatment within ten days of admission. According to the relevant tariff the Insurance Company reserves the right to restrict the payment of benefits to treatment that has been preauthorized.
8. The Insured Individual shall submit the required documents in support of a claim to the Insurance Company within four months from the date of each individual course of treatment.
9. If an Insured Individual is insured with another Insurance Company for such individual's medical expenses if such exists, or a person insured avails himself/ herself of the entitlement to insurance or in connection with statutory health insurance or financing scheme, the Policy Holder or the Insured Individual shall be obliged to notify the Insurance Company without delay regarding the details of such other insurance cover or the statutory benefit arranged or received.

§ 12 CONSEQUENCES OF FAILURE TO ADHERE TO OBLIGATIONS

1. If an Insured Individual willfully or as a result of gross negligence fails to adhere to an obligation incumbent upon him/ her, following the occurrence of a claim, the Insurance Company shall be released from the obligation to pay a Benefit. Where an obligation has been breached willfully or due to gross negligence, the Insurance Company shall pay the Benefit to the extent that the breach has no effect on either the cause of or for the extent of the obligation to pay the Benefit incumbent on the Insurance Company.
2. Knowledge and responsibility on the part of the Insured Individual are to be taken as equivalent to knowledge and responsibility on the part of the Policy Holder.

§ 13 CLAIMS AGAINST THIRD PARTIES AND SUBROGATION

1. The Insurance Company retains all rights of subrogation. If the Policy Holder or an Insured Individual has a right to claim an indemnity from a third party for the same subject matter as the Benefit, the nature of which have nothing to do with the legal conditions of the insurance policy, then an obligation shall exist on the Policy Holder or Insured Individual to assign such claims in writing to the Insurance Company up to the amount of Benefit that is to be paid on the basis of the Insurance Contract.
2. If the Policy Holder or an Insured individual waives such a claim or right to an indemnity without the consent of the Insurance Company, then the Insurance Company shall be released from the obligation to pay the Benefit to the extent that it would have been able to obtain compensation on the basis of the right or claim waived.

§ 14 ADJUSTMENT OF PREMIUM AND BENEFIT RATES/ INSURANCE YEAR

1. The Insurance Company shall be entitled to make changes in the premium or the extent of the Benefits at the beginning of a new insurance period.
2. Changes in premium or Benefits will be notified by the Insurance Company prior to the beginning of a new insurance period.

§ 15 OFFSET CHARGES

The Policy Holder and Insured individual may only set off amounts which they are entitled against claims of the Insurance Company to the extent that the counterclaims are either uncontested or have been established by law.

§ 16 DUE DATE OF BENEFIT PAYMENT/ TERM FOR SUIT TO BE BROUGHT

1. Once the obligation to pay a Benefit on the part of the Insurance Company has been validated, with reference both to the grounds of claim and the amount, the Benefits will be paid within one month.
2. If the Insurance Company rejects a claim, with reference to either the grounds of the claim or to the amount, it shall be released from the obligation to pay the Benefit, if the claim of the Policy Holder has not been upheld as valid at law within a period of six months, unless otherwise prescribed by law. This period will commence once the Insurance Company advises in writing that the claim has been rejected.

§ 17 NOTICES

Notices to the Insurance Company must be in writing addressed to the Insurance Company at the Insurance Company's address. Insurance intermediaries/ agents are not authorised to receive any notices.

§ 18 RESOLUTION OF DISPUTES

All disputes arising from or related to the Insurance Contract shall be subject to the non-exclusive jurisdiction of the UAE Courts.

§ 19 APPLICABLE LAW

This Insurance Contract and the insurance relationship created thereby shall be subject to the laws of the United Arab Emirates.