دبـــــي للتـــــأمـــين
DUBAI INSURANCE
CARE & COMMITMENT SINCE 1970

ACS HEALTH IN DUBAI CFE
CFE Top-Up Health Scheme
Summary of Benefits

You have selected the ACS Health in Dubai CFE cover taken out with Dubai Insurance Company registered under DHA numbers DIC-B1M, DIC B2M, DIC-S1M, DIC-S2M, DIC-G1M and DIC-G2M.
How the cover is applied and the details of the benefits to which you are entitled are set out in this leaflet.
The currency of ACS Health in Dubai CFE is US Dollar (USD or $).

Contents

1/ General

Qualification – affiliation

Those who qualify are individuals or groups of individuals under 65 years of age who reside in Dubai and are insured with Caisse des Français de l'Étranger for "Sickness - Maternity - Disability" and "Accidents at work - Occupational illness".
The Member must, when joining, complete and sign the application form including a medical questionnaire validated by the Insurer. A complementary medical examination may be requested by the Insurer.
The Insurer reserves the right to make acceptance conditional upon the production of any additional information it considers necessary.
The Insured makes a commitment for himself/herself and potentially his/her spouse, and their children aged under 21 years under the condition that they do not carry out a paid work and that they are indeed financially dependent on the Insured.
At the date of acceptance by the Insurer, the member and his/her dependents where appropriate, become the "Insured" and their membership is effective until 31st December of the current year. The membership is then renewed on January 1st of each year by tacit agreement for a period of 12 months, unless terminated by registered mail, no later than October 31st of the previous year.

Choice of formulas

The Plan offers three formulas namely: Bronze, Silver and Gold; the Member opts for one of them as well as for the annual limit of either USD 1,000,000 or USD 2,000,000.
The choice of formula is made by the Insured at the time of joining.
The Member may change the formula until membership is renewed; change takes effect on next January 1.
A change to a formula that provides a lower level of medical cover than that which the Member had previously selected is irrevocable. In the event the Member opts for a higher level of medical cover, he has to complete a new medical questionnaire.

Effect of cover

Under no circumstances may the cover start before the Member has paid the annual premium. The Insurer takes responsibility to pay the expenses for each of the beneficiaries accepted for cover **after it has examined and accepted the medical questionnaire for all expenses**, subject to the payment of the insurance premium, except the following, after the qualifying time set out below and beginning on the date of acceptance by the Insurer that appears on the application form:

- **Pre-existing and chronic conditions : 6 months.**
- **Dental : 6 months.**
- **Optical : 6 months.**

However, regarding pre-existing and chronic conditions: the insured may opt in the application form for the waiver of the qualifying times. In any case, where a pre-existing or chronic condition develops into an emergency within the 6 month exclusion period, this will be covered up to the annual aggregate limit.
Regarding optic and dental covers, the qualifying times do not apply if the Insured can give proof of equivalent coverage at the time of joining or, if cover is interrupted, in the context of the present agreement, for less than one month between two memberships.

Duration of cover

Once accepted for Insurance, and except in the case of false declarations, the Insured may not be barred provided that s/he fulfils the conditions for benefiting therefrom.

In all cases, cover ends:

For each Insured:

- in case of non-payment of the insurance premium,
- on the last day of his/her period of membership,
- on the 31st December of the year of his/her 75th birthday.

For all those Insured:

- on the termination date of the policy registered under DHA numbers DIC-B1M, DIC B2M, DIC-S1M, DIC-S2M, DIC-G1M or DIC-G2M.

Termination (or suspension) of cover simultaneously results, for the Insured, in the removal of entitlement to the benefits for all the treatment and care that occurs from the date of cessation even if they began or were prescribed before that date.

2/ Definitions

The terms and expressions used in this agreement in italics and starting by a capital letter have the following meanings:

Accident: any unintentional bodily injury caused to the Insured, arising from abrupt, sudden and unexpected action with an external cause, to the exclusion of an acute or chronic *Illness*.

Acts of Terrorism / Terror Attack: any act of violence constituting a criminal or illegal attack against people and/or property in the country in which you are staying, and whose purpose is to disturb public order seriously.

Childbirth expenses: medical expenses (including double room) incurred for vaginal childbirth. Any complication including cesarean section if medically necessary, and private room, will be paid for by the "*Hospitalization*" cover.

Civil War: armed opposition between various parties belonging to the same country, and any armed rebellion, revolution, revolt, insurrection, or coup d'état, and any application of martial law or border closure ordered by the authorities of the country in question.

Cost for parent accommodation (child under 18 years of age) or companion accommodation: price of a Hospital room for a parent or companion during the admission of an insured to Hospital for treatment. If a Hospital bed is not available, the Insurer takes into charge the equivalent cost of room up to the indicated amount. Miscellaneous expenses such as meals, telephone calls and newspapers are not covered.

Country of origin: is considered as country of origin, the one stated on the passport of the beneficiaries and / or the country declared as country of origin on the application form.

Dental prosthesis: prosthetic care, including crowns, inlays, onlays, reconstruction or repair, bridges and implants, as well as all necessary and related treatments if dental coverage provided.

Domicile: domicile means the Insured's main and usual place of residence in his/her country of origin.

Emergency: a term used in the event of an *Accident* or the beginning of a serious *Illness* requiring immediate measures and medical treatment for the Insured or one of the Insured's dependents. Only medical treatment given by a doctor, generalist or specialist or *Hospitalization* occurring within twenty-four (24) hours of the direct cause of the *Emergency* shall be considered conditions necessary for reimbursement.

European Economic Area (EEA): countries that belong to the EEA are Austria, Belgium, Bulgaria, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom.

Foreign War: declared or undeclared armed opposition between one state and another state, as well as any invasion or state of siege.

Formal Hospital Admission:

(i) For stays of at least 24 hours, Formal Hospital Admission is the formal acceptance by a hospital or other inpatient health care facility of a patient who is to be provided with a room, board as well as continuous nursing service in the hospital in which the patient resides at least overnight.

(ii) For stays of less than 24 hours in case of *Surgical Procedures*, Formal Hospital Admission is the formal document indicating that the patient is provided with nursing services and a bed, despite the fact that s/he does not stay overnight.

(iii) For stays of less than 24 hours in case of non-*Surgical Procedures*, Formal Hospital Admission is the formal document indicating that the patient has entered the hospital for less than 24 hours for chemotherapy, radiotherapy, dialyses, fibrescopy, colonoscopy, endoscopy treatment for less than 24 hours. The patient enters for treatment and leaves after treatment.

Hospital: refers to any establishment licensed as a medical or surgery hospital in the country where it is located. The establishment must offer its patients ongoing monitoring by a physician. Convalescent and nursing homes, thermal baths and cures at spas, are not deemed to be hospitals.

Hospitalization: refers to:

(i) a stay for at least 24 hours for medical treatments or *Surgical Procedures* in a public or private *Hospital* due to an accident or illness, provided that the insured receives a *Formal Hospital Admission*. In such a case are covered:
- *Surgical Procedures* and corresponding accommodation costs,
- medical and paramedical expenses provided in the context of hospitalization, and
- the transportation of the patient between the patient's home or the site of the *Accident* and the closest hospital located in the same country.

(ii) a stay of less than 24 hours, provided that the insured receives a *Formal Hospital Admission*, in case of:
- *Surgical Procedures*
- fibrescopy, colonoscopy, endoscopy, or
- chemotherapy, radiotherapy or dialyses treatments.

Stays of less than 24 hours for emergency rooms visits which do not result in *Surgical Procedures* are deemed to be outpatient treatments and are not reimbursed as hospitalization expenses.

Illness, Sickness or Disease: a degradation in health established by a medical authority, requiring medical treatment.

Medical prosthesis: hearing aid, phonation aid (electronic larynx), wheelchair and personal mobility aid, artificial limb, ostomy product, hernia support, abdominal bandage, elastic support stockings or orthopaedic sole and any other medically prescribed apparatus.

Natural Disasters: abnormal intensity of a natural element not arising from human intervention.

Pollution: degradation of the environment by substances that are not naturally present in the medium in question being discharged into the air, the water, or the soil.

Prescribed Medication: designate medication sale and use of which are legally subject to a doctor's prescription. Medication that can be purchased without a prescription is not included in this definition.

Prescribed spectacle lenses, frames and contact lenses: reimbursement of an eye exam by an optometrist or an ophthalmologist per insurance year and of contact lenses or glasses to correct vision.

Sécurité Sociale: the voluntary insurance of the Caisse des Français de l'Etranger (CFE) for the risks of "Sickness – Maternity – Disability" and "Accident at work – Occupational illness".

Strike: concerted collective action consisting in the employees of a firm, of an economic sector or of a professional category ceasing to work in order to give weight to their claims.

Subrogation: legal situation whereby the rights of one person are transferred to another person (in particular: the Insurer taking the place of the Contrat holder for the purposes of proceedings against the opponent).

Surgical procedures: acts carried out under general or local anaesthetic or the reaching of an organ to be treated after an incision are deemed to be surgical procedures.

Waiting period/ qualifying time: period during which the Insured is not entitled to certain benefits.

3/ Health cover and benefits

Coverage zone

Medical expenses are repayable in the expatriation zone chosen by the Insured, as indicated in the application form.

The choice is made between one of the following zones:
Zone A: GCC only (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates)
Zone B: GCC + European Economic Area (excluding United Kingdom)
Zone C: Worldwide excluding United Kingdom, Switzerland, USA and Canada

However, during a stay of less than seven weeks in a country outside the expatriation zone, only expenses arising from an *Accident* or an *Illness* of an urgent nature as defined above under *Emergency* provided that the treatment has been given by a doctor, generalist or specialist, or that the *Hospitalization* was required as a direct cause of the *Emergency* and that it took place within 24 hours, shall be reimbursed.

In other cases, on express approval by the Insurer.

Illness – Surgery – Maternity cover

Only the benefits corresponding to the subscribed guaranties are covered. The list of these guarantees is indicated on the table attached to the present summary of benefits and varies according to the chosen formula.

Subject to the exclusions below, within the limits of the chosen formula and as indicated in the table of benefits on page 12 of this document, **medical expenses supplementing the benefits in kind of the "Sickness - Maternity - Disability" insurance and "Accident at work - Occupational illness" insurance of the Caisse des Français de l'Étrange, are covered.**
Furthermore, requests for reimbursement will be honored only if the Insurer considers the amount of the bills and the receipts supplied to be reasonable, within normal limits and corresponding to medically justified interventions.
Otherwise, the Insurer reserves the right to reduce the amount of benefit.

Amount of benefit

The amount of benefit is determined for each expense item according to the terms indicated on the table of sums insured.
Reimbursements are paid, after deduction of the CFE's benefits, up to the maxima indicated on the table of sums insured and up to the limit of the actual costs.
By actual costs one must understand medically justified, normal and reasonable costs based on the tariffs currently charged by medical institutions and practitioners in the country or state concerned.

The benefits paid by the Insurer are in addition to those of any other Life and Accident insurance scheme from which the Insured may benefit personally.

By annual limit one must understand the limit per civil year.

Limitation to actual cost

Reimbursements or payments covering expenses caused by an *Illness*, maternity or an *Accident* shall not exceed the amount of the expenses for which the Insured remains liable after the reimbursements of all kinds to which the Insured is entitled.

Similar cover taken out with several insurance organizations shall have an effect on the limit of each item of cover irrespective of when the cover was taken out.
In this limit, the beneficiary of the Agreement may obtain additional payment by sending details of the reimbursements made by the other organization(s).
For application of the aforementioned arrangements, the limitation of expenses for which the Insured is still liable is determined by the Insurer for each of the treatments or expense items.

The Insurer reserves the option to modify the cover in one or more specific territories subject to notifying the Subscriber 15 days in advance.

4/ Formalities necessary when claiming medical expenses

In the event of *Hospitalization*, the Insured may obtain a guarantee of payment, in order to prevent making advance payments.

Your contact information for guarantees of payment and for other expenses:

WHEALTH INTERNATIONAL
P.O. Box 26568
Dubai, UAE

For general enquiries inside UAE: Toll Free 800-WHEALTH (9432584)
In case of emergency Only Inside UAE: 04 392 7105
Outside UAE: +971 4 379 2949
Fax number: +971 4 3990739
e-mail : claims@whealth-international.org

In the event of illness: the detailed bills with prescriptions and medical expense claim forms including the stickers for reimbursement of medication costs.

In the event of *Hospitalization* (if a refund is not delivered): the paperwork providing proof of *Hospitalization*, bills, fees.

In the event of home confinement: a birth certificate of the child.

The Insurer may request any other additional supporting documentation it requires.

No copy, photocopy or duplicate invoice is accepted.

Prior approval

Reimbursements of:

- *Hospitalization* expenses (in *Hospital* or at home)
- physical rehabilitation that immediately follows a *Hospitalization*
- MRI
- physiotherapy (if over 10 sessions)
- physical therapy
- chiropractic, osteopathy, homeopathy, acupuncture

- *Childbirth Expenses*

is subject to the Insurer's prior approval, except in the event of *Emergency* (as defined in this Plan). Each admission to a *Hospital* must be notified to the Insurer at least 10 days prior to the effective admission, and within 24 hours for *Hospitalizations* following an *Emergency* (as defined in this Plan).

We reserve the right not to reimburse expenses that have not been notified beforehand, as required by the Plan.

In the event of *Hospitalization*, surgery, radiography or medical treatment, a medical certificate must be requested from us in advance. It should be returned to us after having been completed by the doctor of the Insured.
Any failure to fulfil this obligation could result in a refund being refused.

The Insurer reserves the right to require any Insured person or beneficiaries to provide all the information necessary for the processing of their personal data and data relating to claims for reimbursement. The Insurer may therefore have access to their medical files with all the legal obligations of confidentiality attached thereto.

Any information supplied by the Insured or one of their beneficiaries that is incorrect, falsified, exaggerated or any fraudulent acts on their part shall be the direct responsibility of the Insured and shall give rise to the repayment of the monies unduly paid by the Insurer on the basis of such incorrect information.

5/ Assistance cover

Repatriation assistance

If the Insured is in one of the situations listed below, we provide the services described, requiring no more than a telephone request (reverse charges accepted from abroad) or a telex, fax or telegram request.
In all cases, the decision to provide assistance and the choice of the appropriate means shall lie exclusively with the Insurer's doctor, after making contact with the treating doctor at the location and, where necessary, the family of the beneficiary.

Only the medical interests of the beneficiary and compliance with the applicable health regulations shall be considered for deciding on the transport, the choice of the means used for transport and any place of *Hospitalization*.

In no cases will we become a substitute for local emergency services.

Repatriation or medical transport

If the Insured is ill or injured following a covered event and the Insured's state of health requires a transfer, we organize and pay for repatriation to:
- either the competent hospital closest to the Insured's place of expatriation
- either the competent hospital closest to the Insured's home in his country of origin
- either the Insured's home in his country of origin;

if the local medical infrastructure does not have the capacity to provide appropriate care.

Depending on the seriousness of the case, repatriation or transport is carried out under medical supervision, if necessary, by the most appropriate of the following means:
- special medical aircraft
- regular scheduled airline, train, sleeper train, ship, ambulance.

Accompaniment in case of repatriation or medical transport
Following the repatriation or the medical transport of the Insured, we organize and pay for the additional costs of transporting members of the Insured's family who are covered or a person insured under this agreement accompanying the Insured if the tickets provided for their return to their country of origin cannot be used because of the repatriation.

Transport of the body in the event of death

We organize and pay for transport of the Insured's body from the place where the body has been placed in a coffin to the international airport closest to the home of the Insured.

We also pay the ancillary expenses necessary for transportation, including the cost of the coffin, making transport possible, up to the amount indicated in the table of sums insured.
Costs of the ceremony, accessories, burial or cremation remain the responsibility of the families.

We organize and pay for the additional costs of transporting members of the Insured's family who are covered or a person insured under this agreement accompanying the Insured if the tickets provided for their return to their country of origin cannot be used because of the repatriation.

Return of the Insured after "consolidation" (when healing is complete)

Following the repatriation of the Insured to his/her country of origin, if a medical authority determines that the state of health of the Insured has consolidated and that it allows the Insured to return to his/her country of expatriation, we pay for the Insured's transport to the international airport closest to his/her place of expatriation. We also pay for the transport of members of the Insured's family who are covered or of a person who is insured under this agreement and accompanying the Insured.

Early return

If the Insured has to interrupt his/her stay abroad because of one of the below mentioned events, we will pay for the Insured's additional transport costs and those of the Insured's covered family members* or those of a person insured under the present contract accompanying the Insured, if their travel tickets provided for their return to their Domicile cannot be used because of this event.
The guarantee applies in case of one of the following events: A serious *Illness* or a serious *Accident* resulting in a hospitalization of more than 10 days, or the death of a family member* of the Insured.
We also take into charge the transport costs for the return of the Insured to his country of expatriation.

***Family members**: Family members are defined as spouse, children, brothers or sisters, father and mother.

Obligations of the Isured in the event of a claim

For any request for assistance, the Insured must contact Mutuaide at any time of the day or night:

- by telephone +33 (0)1 45 16 65 98
- by fax +33 (0)1 45 16 63 92 or +33 (0)1 45 16 63 94
- by e-mail: medical@mutuaide.fr

and obtain our consent prior to taking any initiative or committing to any expenditure including medical costs.

When we have organized the Insured's transport or repatriation, the Insured must send us his/her initial tickets, since they become the property of the Insurer.

6/ Exclusions

Special Exclusions to Health benefits:

It is understood and agreed that medical expenses not recognized by the World Health Organization are not covered in this agreement, except for prescribed contact lenses.
Furthermore, and in addition to the section below "General exclusions for Health and Assistance cover", the following risks and benefits are excluded even if they would have otherwise been reimbursed by the World Health Organization:

- **healthcare Services which are not medically necessary,**
- **treatments outside the geographic zone of expatriation as indicated in the application form, except for cases specified in the section on the zone of coverage,**
- **any form of experimental or unsupervised treatment that does not follow commonly accepted, customary or conventional medical practice, unless specific consent has been given by the Insurer,**

- **any inpatient treatment, investigations or other procedures, which can be carried out on outpatient basis without jeopardizing the Insured Person's health,**
- **incidental expenses or comfort expenses in the case of *Hospitalization* (telephone, television, etc.),**
- **treatments for drug addiction or alcoholism,**
- **expenditure incurred on the acquisition of an organ (but not the organ itself),**
- **any operation or treatment relating to a sex change,**
- **aesthetic treatments, age-reducing treatments, slimming treatments,**
- **the checks, examinations, treatments and complications associated with sterility, sterilization, sexual dysfunction, contraception including the insertion or removal of contraceptive devices, the voluntary termination of pregnancy except in the case of a pregnancy termination that is medically necessary and complies with local legislation,**
- **any elective/voluntary surgery and/or plastic/cosmetic surgery,**
- **services rendered by any medical provider who is a relative of the patient for example the Insured person himself or first degree relatives,**
- **Spa treatments,**
- **transport and accommodation costs associated with Spa treatments,**
- **consultations, treatments and complications associated with the loss of or implantation of hair unless the treatment is related to a hair loss caused by a serious *Illness*,**
- **medical expenses associated with a stay at a thalassotherapy centre or fitness centre, rest home or recovery home even if this stay is medically prescribed, (except for reeducation centres immediately following a *Hospitalization*),**
- **outpatient consultations with regards to psychotherapy, psychoanalysis and psychiatry, as well as related medication,**
- **treatments to modify the refraction of an eye or the eyes (laser eye correction), including refractive keratotomy (KR) and photorefractive keratotomy (KPR),**
- **unprescribed medication, and commonly used non-medical products such as medical alcohol, absorbent cotton, suncreams, dental hygiene products, dressings, shampoos etc.**

<u>Special Exclusions to assistance benefits:</u>

In no circumstances can we be a substitute for local emergency services.
We cannot take action when the requests for cover and benefits are the consequence of losses resulting from:

- **convalescence and disorders (*Illness*, *Accident*) being treated that are not yet consolidated on the date the journey begins,**
- **pre-existing conditions that are diagnosed and/or treated that have been the subject of hospitalization in the six months prior to the request for assistance,**
- **journeys undertaken for the purpose of diagnosis and/or treatment,**
- **conditions resulting from the ingestion of alcohol, the use of drugs, narcotics and similar products that have not been medically prescribed,**
- **the consequences of suicide attempts,**
- **epidemics, and *Natural Disasters*,**
- **alcoholism, drunkenness, the use of medications, drugs, narcotics that are not medically prescribed,**
- **any intentional act that may involve the cover of the agreement,**
- **duels, bets, crimes, brawls (except legitimate defense),**
- **the practice of the following sports: bobsleigh, skeleton, mountain climbing, competitive luge, air sports except for parascending and those resulting from participation in or training for official matches or competitions organized by a sporting federation,**
- **activities when an insurer is banned from providing a contract or an insurance service due to a sanction, restriction or prohibition provided by conventions, laws or regulations, including those decided by the United Nations Security Council, the European Union Council or any other applicable national law,**
- **activities when they are subject to any sanction, restriction total or partial embargo or prohibition provided by conventions, laws or regulations, including those decided by the United Nations Security Council, the European Union Council or any other applicable national law. It is understood**

that this provision only applies in the case where the insurance contract or insured activities fall within the scope of the decision concerning the restrictive sanctions, total or partial embargo or prohibition, and
- **the absence of random.**

In addition, we cannot be held liable for failures in the execution of the Assistance services resulting from cases of force majeure or the following events:
***Civil* or *Foreign Wars*, acknowledged political instability, popular movements, riots, *Acts of Terrorism*, reprisals, restrictions to the free circulation of people and goods, *Strikes*, explosions, *Natural Disasters*, meltdown of atomic cores, nor delays in the execution of services resulting from the same causes.**

General exclusions for Health and Assistance cover

Expenses incurred are not paid by the Insurer if they result from the following:
- **an *Illness* or *Accident* due to the intentional act of the insured person, intentional mutilation or attempted suicide,**
- **criminal proceedings against the Insured,**
- **the consequences of a *Civil* or other *War*, insurrection, *Terror Attack* or popular movement,**
- **riot or *Strike*, except if the Insured does not take an active part in the event,**
- **a claim resulting directly or indirectly from the meltdown of an atomic core, or any irradiation originating from ionizing radiation.**

7/ Premiums

Determination of premiums

The premium to be paid for this medical insurance is calculated for each Insured according to his age and the category of cover selected.
The age that is taken into account is the one that is reached on December 31 of the year that membership of the Plan commences. Upon renewal of the membership, it will be revised according to the changes made in age brackets as defined in the premium scale.

Revision:
Premiums are automatically indexed on January 1 of each year, according to the annual consumption of medical care and medical inflation. Premiums are also revisable by the Insurer each January 1, depending on the Plan's technical results.

Payment of premiums

Premiums are payable yearly. Cover may start only after receipt of the full annual premium.
At renewal, the annual premium has to be paid within one month of the sending of the renewal terms, or the contract may be terminated

8/ Legal action

The beneficiary grants *Subrogation* to the Insurer to take any legal action against a liable third party.

9/ Prescription

Any legal action or any claim for insurance benefit settlement deriving from this plan is prescribed one calendar year calculated from the date on which the event has occurred.

10/ Basis of the insurance agreement

APPLICABLE LAW

This agreement is governed by the laws of Dubai. The definition of the cover, the premiums and their rules of application take into account the regulations of the World Health Organization that are applicable on the effective date of the insurance Plan.

DISPUTE RESOLUTION

All disputes arising out of or in connection with this policy, including any question regarding its existence, validity or termination, shall be referred to the courts of Dubai exclusively.

ANTI MONEY LAUNDERING

The controls that we are legally required to carry out as part of anti money laundering and to combat the financing of terrorism, especially cross-border flows, may lead us at any time to ask you for explanations or supporting documents.

11/ Administration

For any questions regarding administration of membership, premium collection or administration of claims, please contact:

Whealth International LLC
P.O. Box 26568
Dubai, UAE
For general enquiries inside UAE: Toll Free 800-WHEALTH (9432584)
Outside UAE: +971 4 379 2949
e-mail : claims@whealth-international.org
www.whealth-international.org

12/ Mediation

WHAT IS THE PROCEDURE FOR EXAMINING COMPLAINTS?

Your usual contacts are able to study in depth all your requests and complaints. If, after this review, the answers do not meet your expectations, you can submit your claim to:

Whealth International LLC, Complaints department,
P.O. Box 26568
Dubai, UAE
Or register your complaint at:
www.whealth-international.org

دبـــــي للتـــــأمـــين
DUBAI INSURANCE
CARE & COMMITMENT SINCE 1970

13/ Tables of benefits

DUBAI - all amounts in USD	BRONZE	SILVER	GOLD
ANNUAL LIMIT	US $ 1 000 000 or US $ 2 000 000	US $ 1 000 000 or US $ 2 000 000	US $ 1 000 000 or US $ 2 000 000
NETWORK (1)	Platinum	Platinum	Platinum
INTERNATIONAL MEDICAL ASSISTANCE	Yes	Yes	Yes
HOSPITALIZATION (with prior consent)			
Hospital fees (accommodation, medicines, ICU, Doctors' fees etc.)	100% - private room	100% - private room	100% - private room
Cancer treatment	100%	100%	100%
Rooming-in: parent accommodation (child under 18) or companion accommodation	$160 per night	$160 per night	$160 per night
Home nursing	$100 per day (30 days)	$100 per day (30 days)	$100 per day (30 days)
Immediate rehabilitation after hospitalization	100%	100%	100%
Ambulance (emergency transportation)	100%	100%	100%
Pre-existing and chronic conditions	6 months waiting period (2)	6 months waiting period (2)	6 months waiting period (2)
ROUTINE MEDICAL TREATMENT			
Consultation fees	100%	100%	100%
Medication	100%	100%	100%
X-rays and laboratory services	100%	100%	100%
Physiotherapy	100%	100%	100%
Alternative medicine (Osteopathy, Homeopathy, Acupuncture and Chiropractor)	$ 750	$ 750	$ 750
Cancer treatment (tests, drugs etc.)	100%	100%	100%
MRI, CT and PET SCANS	100%	100%	100%
Outpatient Surgeries	100%	100%	100%
Medical supplies and appliances, prosthesis	$ 350	$ 350	$ 350
Deductible (applicable to consultations only)	20% - max $ 14	20% - max $ 14	Not applicable
Pre-existing and chronic	6 months waiting period	6 months waiting period	6 months waiting period
OPTICAL (6 months waiting period)			
Eyeglasses, Frames and contact lenses	Not available	$ 400 (2 years)	$ 500 (2 years)
DENTAL (6 months waiting period)			
Minor & major dental treatment, orthodontic treatment if under 18	Not available	1 500 USD $ 375 per tooth	2 000 USD $ 500 per tooth
EMERGENCY			
Accidental damage to natural or artificial teeth	100%	100%	100%
Dental and gum treatments and diagnosis	100%	100%	100%
Hearing and vision aids, laser surgery (vision correction)	100%	100%	100%
CHECK-UPS			
Routine annual examinations	$ 350	$ 350	$ 600
MENTAL AND NERVOUS DISORDERS			
Inpatient	$ 5 000	$ 5 000	$ 5 000
Outpatient	$ 2 600	$ 2 600	$ 2 600
ORGAN TRANSPLANT			
Cost of surgical procedure for receiver only	$ 400 000	$ 400 000	$ 400 000
MATERNITY: IN-PATIENT			
Normal (routine) maternity (co-payment 10%)	$ 5 000	$ 5 000	$ 7 500
Complicated maternity (co-payment 10%)	$ 10 000	$ 10 000	$ 15 000
MATERNITY: OUT-PATIENT			
Consultation fees, medication etc.	100%	100%	100%
NEW BORN COVER	Covered for 30 days from birth including BCG, Hepatitis B and neo-natal screening test (Phenylketonuria, Congenital hypothyroidism, sickle cell screening, congenital adrenal hyperplasia)		
PREVENTIVE SERVICES			
Vaccinations as per DHA policies	100%	100%	100%
Initial Diabetic screening	100% every 3 years from age 30 100% every year from age 18 if high risk individual	100% every 3 years from age 30 100% every year from age 18 if high risk individual	100% every 3 years from age 30 100% every year from age 18 if high risk individual

(1) Out-of-Network treatments : 20% co-pay
(2) Where a pre-existing or chronic condition develops into an emergency within the 6 month exclusion period, this will be covered up to the annual aggregate limit

ASSISTANCE AND REPATRIATION			
	BRONZE	SILVER	GOLD
Emergency medical evacuation & repatriation	100%		
Transport of the body in the event of death:			
- Repatriation of the body	100%		
- Funeral expenses required for transportation	$ 1 500		
- Repatriation of other family members	Ticket (one way only)		
Return of the insured to the country of expatriation after "consolidation"	Ticket (one way only)		
Early return	Ticket (round trip)		