Policy handbook Health Perfect and Secure Series

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1 Introduction

Your insurance policy comprises your membership statement and benefits table, your membership card, details of your hospital network and other documents related to our services including where applicable any contract we may have with the policyholder who may be the head of the family or your employer.

This handbook, which forms part of this contract, has been designed to set out the key features and benefits of your Healthcare Plan and to clarify our position on some aspects of your cover. It includes general terms, conditions, definitions and exclusions applicable to all members covered by one of our Healthcare Plans.

Details of your personal cover are included in your membership statement and benefits table. If there is anything you would like to clarify further please call our Customer Service Team on the number shown on your membership card.

Please take a few moments to refresh your memory about the AXA Healthcare Plan then relax and look forward to the highest standards of service from AXA Insurance. You can rest assured that, whatever the coming year brings, we'll be there to support you.

What your health insurance cover is designed to do?

As with all insurance policies your AXA Healthcare Plan is there to cover you for costs arising from an unforeseen event. For healthcare insurance this means the cost of eligible treatment resulting from an unexpected illness or accident.

You must take care of your own health and not only rely on healthcare professionals to do this for you. When something unfortunate does affect your health we will do our best to help you but we must always act within the limits of your policy.

What our service team is there to do?

It is the role of our Customer Service Team to assist you, wherever possible, within the terms and limits of your AXA Healthcare Plan. If you need to call us you will find our number on the reverse of your membership card. For your reference it is:

UAE: 800 2926

Qatar: 800 2921

Bahrain: 800 010 60

Oman: 800 702 92

Please see your membership card for details of your local office in the AGCC where applicable.

Please take a note of this and keep it in a safe place where you can find it easily. Please have your membership card with you whenever you call our Customer Service Team. The information on your card will help them to deal with your enquiry as quickly as possible.

2 Important note about pre-existing conditions

Why it is important to tell us about pre-existing conditions?

Pre-existing (including pre-existing chronic) conditions are those that a member already had, already knew about, should reasonably have known about or for which there were symptoms before the policy started.

Before you were accepted for cover you were given the opportunity to tell us about any pre-existing (including pre-existing chronic) conditions even if you only had symptoms.

Cover for such conditions and anything related to them is taken from benefit number 21.

It is important that you have shared any information about such pre-existing conditions so that we can accurately assess and quickly pay your claims.

If you have not shared this information with us we may have to delay a pre-approval request or claim or may not be able to cover that undeclared condition at all.

Whether or not you told us about any such conditions, or missed some relevant details, we have the right, based on our medical knowledge and experience, to decide that a condition was likely to have been symptomatic or diagnosed before your policy first came into force.

Our decision in such cases is final and we will therefore only provide cover for such conditions in accordance with benefit number 21.

The terms of your membership agreement will apply in any event.

3 In case of emergency

Emergency treatment

We know that in a real emergency you may not have time to contact us for pre-authorization or help with your case. In such circumstances we take a pragmatic approach, so, we ask you to contact us beforehand if you can and it is safe to do so. If it is not, and you need immediate treatment please make that your priority.

Do, however, ask somebody to contact us as soon as possible and make sure that, at the earliest opportunity, whoever is providing treatment is given your membership card and proof of identity so that they can contact us straight away. In any event, under these circumstances, our authorization must be sought and given before you are discharged from care otherwise you may be required to pay the entire cost of your treatment and submit a reimbursement claim to us.

International Emergency Medical Assistance (I.E.M.A.)

If 'IEMA' is included in your benefits table you have access to International Emergency Medical Assistance. This is a worldwide, 24 hours-a-day, 365 days-a-year emergency service providing evacuation or repatriation services. If you need immediate emergency in-patient treatment, where local facilities are unavailable or inadequate, a phone call to the Emergency Control Centre on: +971 4 4294000 will alert the International Emergency Medical Assistance service. Please see the separate leaflet for full details. Please note that, for your own protection, calls may be recorded in case of subsequent query. Access to this service is provided by AXA Travel Insurance. Please note that entitlement to the evacuation service does not mean that the member's treatment following evacuation or repatriation will be eligible for benefit. Any such treatment will be subject to the terms and conditions of the member's plan.

4 How to get the best from your plan

Before you go for treatment

Contacting us before receiving treatment

We require you to contact us before receiving any planned admission and some major outpatient treatment. This allows us to help you in a number of ways: by managing your admission and billing, by confirming to you and whoever is giving you treatment that your claim will be eligible, at what cost and for how long treatment is approved. In the unlikely event that there is any difference between our confirmed level of cover and what is requested by the hospital when you are discharged you must make arrangements to pay this before leaving hospital. If you do not contact us it is possible that you will have to pay for all or part of your treatment.

When we pre-authorize cover we will confirm;

- The planned treatment is eligible under your policy;
- The planned treatment is medically necessary;
- The planned treatment is provided to you for the appropriate duration in case of admission and at appropriate frequency in case of outpatient;
- The planned treatment is within the eligible costs for the services;
- The planned treatment costs falls within the remaining benefit limit of your plan.

Our agreement with you requires you to seek pre-authorization for the following treatment and services:

In-patient and daycare

- All inpatient and daycare admissions and extension of stay
- All investigations including diagnostics and imaging
- All surgery and similar procedures

Out-patient

- Non-emergency MRI, CT, PET and Gait; scans and internal diagnostics such as but not limited to endoscopy, colonoscopy, gastroscopy, etc;
- Physiotherapy services;
- Prescriptions for more than 1000 AED or equivalent and/ or prescriptions for more than one month as well as all prescriptions involving medical devices and/or equipments;
- All out-patient dental services received on direct billing basis;
- All psychiatric treatment
- Alternative and complimentary treatment.

If you do not obtain pre-authorization as mentioned below it may prevent us from settling all or part of any claim. If we are obliged to pay for any item not covered by our confirmation we will have to recover that amount from you. In any event any cost that is not directly related to treatment will be borne by the member.

Pre-authorization before an admission may protect you from paying the bill

We try very hard to pre-authorize most treatment within a few hours. However sometimes we need more information about the medical condition, the planned treatment or the medical practitioner. This can take a little time and delay the approval. This is particularly the case when you choose or are obliged

to use a provider outside our network or one who is not recognized by us. When this happens you must pre-authorize your treatment at least 2 weeks for elective treatment outside network before admission and you must confirm with the provider that our written approval has been received before you undergo treatment. If it has not, you must contact us immediately.

We must be advised of any proposed treatment before treatment begins. If you do not allow us to manage your case, wherever treatment is received, you may be exposed to additional costs.

What we mean by 'recognized by us'

Around the world there are many highly trained and skilled practitioners and organizations but there are also those who, while being able to demonstrate professional qualification, do not meet acceptable standards of care, experience and/or integrity. We do not 'recognize' those who do not meet our standards in this regard. Therefore if you choose to use an 'unrecognized' practitioner or provider we will not be able to settle your claim.

It is very important that you check a practitioner or provider's recognition status with us before undergoing treatment.

Decisions about your treatment

We do not decide whether the treatment you receive is given on an in-patient, daycare or outpatient basis. This is decided by the attending medical practitioner. We will not usually question this unless, in the opinion of our medical team, it would have been more appropriate for treatment to have been given differently. In the unlikely event of this happening we will ask for an explanation of why the particular method of treatment was chosen. We recognize that there may have been a valid reason for the choice made by the medical practitioner. Our intention in questioning such matters is to be able to fairly and accurately assess any claim.

Reasonable and Customary Charges

All benefits and services submitted for reimbursement of claims shall be evaluated based on the Reasonable and Customary Charges. AXA will pay the actual cost incurred or the Reasonable and Customary rates against the service whichever is less and the level of reimbursement shall be decided based on the Network offered.

The following conditions would apply:

i. Co-insurance/Deductible as applicable under the plan would be deducted wherever applicable from the eligible amount prior to reimbursement

ii. Pharmacy will be paid on actual as per terms and conditions of Policy.

iii. Benefits/Services not included in the list of the Reasonable and Customary rates shall be dealt with on a case to case basis.

iv. The actual amount payable shall be based on the itemized bill submitted and the codes used per service by the Service Provider. Where itemized bill is not submitted and where service provided are without defined codes they would be assessed on a case to case basis.

v. Reasonable and Customary rates factor shall be based on the country where

Policy is issued and shall be applicable for treatments taken within the AGCC.

vi. Where no network exists or the treatment is not available within the network providers (for treatment in countries where Reasonable and Customary rates are not available), AXA Insurance will base the calculation on the average cost of the treatment in that area or country; or the network in the principle country of residence.

vii. Special arrangements if any would reflect in the Table of Benefits issued by AXA.

Second opinion

We can ask an independent medical practitioner to advise us about the medical fact relating to a claim or to examine the member concerned in connection with the claim. This is needed only very rarely and we use this right only where there is uncertainty as to the nature or extent of the medical condition and/or our liability under the policy.

If you need treatment abroad

If you need treatment abroad, you will need to call AXA Insurance on +971 (4) 429 4000 or one of the numbers shown on your membership card.

If your medical practitioner recommends hospitalization or a major out-patient procedure then call one of the below telephone numbers to confirm that you are entitled to the benefit.

Any bills, together with your completed claim form, should be sent to:

The address of your local AXA Insurance office can be found on page 29.

While you are having treatment

Identifying yourself as an AXA member

We have negotiated advantageous terms with hospitals and practitioners around the world.

This is to your advantage as your benefits are eroded more slowly because treatment costs are usually lower than average. To make sure you are benefiting from this, prior to receiving treatment anywhere, you must identify yourself and your eligibility for discounts by showing your AXA medical ID Card, together with a recognized official form of identification, such as a passport, to any provider to show that you are an insured member of an AXA insurance healthcare policy. If you do not ensure that the provider recognizes your entitlement to our discounted services you may have to pay any difference between the invoice value and our negotiated price.

Any questions?

Although we have tried to include as much useful information in this handbook as possible if you have any questions about your cover then please direct these, either to your HR Department for company schemes or AXA Insurance for individual and family policies.

Details of how to contact us are shown on the introductory page.

Claim forms	You can visit our website at www.axa-gulf.com to obtain a printable claim form if you need one. You must provide a completed claim form, signed by the medical practitioner and the member, for any visit whether this is to a practitioner, hospital, clinic, pharmacy, diagnostic centre or any other facility where medical services may be received.
Claim forms inside our directbilling network	When you register at a direct-billing network and identify yourself as a member you should be given a claim form. If not, please ask for one. It is your responsibility to ensure that this is fully completed and signed by you and the attending medical practitioner. The direct-billing network hospital will send the completed claim form to us. Outside the AGCC you will need to print a claim form from our website before receiving treatment and take it with you for the Medical Practioner to complete and sign.
Claim forms outside our direct-billing network	If you are not being treated in a hospital listed in the direct billing network covered by your plan a different process applies. You must take a claim form with you (available from our website) and make sure it is filled in and signed by yourself and the medical practitioner treating you and sent back to us as quickly as possible, giving us all the information we request (Only original receipted invoices can be accepted with your claim). A fully completed claim form will ensure your claim will be processed promptly. An incomplete or unsigned claim form may delay settlement of your claim and in some cases may lead to the claim form being returned to you for completion. It may be necessary for us to obtain a medical report from the attending medical practitioner. If the medical practitioner does not respond quickly to such a request your claim may be delayed. We do not pay for medical reports. For treatment requiring our pre-authorisation such approval must be received from us, in writing, prior to treatment commencing. A copy of that authorisation must be included in your subsequent claim. Please note that, for reimbursement claims, we will only consider claims made within 90 days of treatment being received. You can visit our website: www.axa-gulf.com/uae/en/group-healthcare to obtain a printable pre-authorisation form if you need one.
Where to send your claims	Any bills, together with your completed claim form, should be sent to: The address of your local AXA Insurance office can be found on page 29.
Payment in local currency	Regardless of your area of residence you must pay your premiums in United Arab Emirati Dirhams, Bahraini Dinars, Omani Rials or Qatari Riyals. Claims reimbursement will be paid in the same currency unless we have previously agreed otherwise in writing. Benefits paid in a local currency will be converted using the closing midpoint exchange rate published in the Financial Times Guide to World Currencies current when we assess the claim.

5 Understanding our position on certain medical conditions

Our position on chronic conditions first arising after you have been accepted for membership

We provide cover for such conditions up to the limit shown for the benefit number 21 in the Benefit Table applicable to your plan. This benefit is only available for treatment of chronic conditions for which first symptoms became apparent after the member was accepted by us for cover on a particular plan.

If there were any symptoms prior to inception of your policy these must have been declared to us, in good faith, in accordance with the previous section. Provided such a declaration was made and accepted by us treatment of the condition will be covered under the 'Pre-existing conditions' benefit shown for your plan.

Please note that the limit shown for this benefit under your plan applies for each member each year and is an aggregate one. Thus the level shown is for all such conditions collectively. Only recognized, proven and necessary treatment, prescribed by a medical practitioner, will be eligible for benefit.

Our position on genetic testing

We do not pay for genetic tests even as part of health screening, nor for any counselling made necessary following genetic tests, when those tests are undertaken to establish whether or not the member may be genetically disposed to the development of a medical condition in the future. This is because such tests are carried out for purposes of establishing whether a medical condition might develop and not for the identification of treatment of a medical condition. It follows that benefit cannot be paid for genetic testing or associated counseling carried out for such purposes.

Our position on psychiatric illness

Your policy covers treatment of psychiatric illness up to the level shown in the benefits table for your plan. The member being treated or any member of his/her immediate family must contact us to obtain our written approval of the treatment planned and the proposed cost before treatment begins.

Please note that the member will be required to pay 30% of any benefit we pay.

6 Administering your policy

What happens when you want to move to another plan

You can ask us to upgrade or downgrade your cover at any policy anniversary. Please tell us at least 30 days in advance so that we can be sure that any change takes effect from the renewal date. We will do our best to accommodate your request but we reserve the right to decline any request to amend your cover. In the event that we do accept a request for an upgrade we may restrict cover for conditions existing at the time of the upgrade to the level of benefits enjoyed under the original policy. In the case of a downgrade in cover new policy terms will apply immediately upon renewal. In any event, final acceptance of any amendment by us will only be made at the next renewal following such a request. Amendments cannot be made during the policy year under any circumstances. Any condition known about or that should reasonably be known about at the time of any amendment must be advised to us, in good faith, before the policy amendment takes effect.

What to do if you wish to add other members to your policy

If you want to add someone else to an existing policy we will send you the forms to complete and you must give all the information we request.

You can ask to add family members to your policy at any time. Any newborn infant may be added to the mother's policy within 30 days of the moment of birth, with the child's cover being effective from that point, provided the mother's cover is in force at the time of delivery.

If the mother is not covered by us at the time of delivery a newborn baby may only be added to the father's policy and be eligible for benefit after final discharge of the child into parental care. Please note that we are not obliged to accept any additional member. If we do accept an additional member during the policy year we may add an administration fee to the pro rata premium charged.

The additional member's policy anniversary will be the same as that of the original policy however any waiting period applicable to a benefit under the policy will start from the date the additional member joins.

Transferring to a policy that is not provided by AXA Insurance

If you are planning to change your principal country of residence (where you live for most of the year) you must tell us. You may transfer to an AXA PPP healthcare UK Plan (in the UK only) or International Health Plan, available at the time of transfer, with no additional medical underwriting exclusions. This can be done when you leave your principal country of residence and cancel your residence permit provided that:

a) Such a plan is available and AXA PPP healthcare may legally provide it in the country to which you are going. You will need to meet any residence or other criteria required for us to be able to provide you with that plan in that country.

b) You provide us with a fully completed and signed application form (both variants are obtainable from the AXA PPP healthcare website or your current insurer) to reach us within one month of the termination of your

local plan or of leaving the country, whichever is earlier. Please ask AXA Insurance for evidence of recent membership if you do not already have it in the form of your current or most recent membership statement.

c) You have been a member of your current AXA Insurance plan for a minimum of one year and have paid your premiums for that period.

d) You accept the price offered by AXA PPP healthcare in the UK for the plan you have chosen.

This will be above the normally published rate for that plan and reflects the increased risks posed by such transfers.

Please note that we reserve the right to deny cover if we believe that the transfer is being requested just to obtain enhanced benefits for a condition about which you are or reasonably should be aware. You must, in good faith, declare any such conditions on your application form at the time of requesting a transfer.

In the first instance please contact the AXA PPP International Sales Centre on **+44 (0)1892 512345**, if you are thinking about or actually wanting to make a transfer. You will need to give your approval for AXA Insurance to release your policy history. Transfer administration can be complicated so, by giving us as much notice as possible, you will help to ensure your new cover starts when it is needed.

Where AXA PPP healthcare is unable to provide continuous cover we will, with your permission, provide all possible details of your claims history with us to any company to which you are applying to help both you and they to make an informed decision about your transfer request. It will be the company to which you are applying that will agree with you, if cover can be provided, at what level that will be.

What happens if you wish to cancel your policy

You may cancel your policy at any time by giving us no less than 30 days notice in writing.

Bearing in mind that this is an annual contract we will not refund premiums if any claim, however small, has been made in the current policy year. In the event that we do agree to make a refund (and this will be at our sole discretion), we will only refund premiums on a pro-rata basis from the end of the Gregorian calendar month in which cancellation takes effect.

Note: We will make an administrative charge of no less than 20% of the annual premium for any cancellation to which we agree. Please also note that no claim of any kind will be considered after notification by you and acceptance by us of any cancellation.

For group policies where the number of employees (absolute minimum six) determines eligibility for a discounted group premium we reserve the right to apply a minimum premium requirement reflecting that number of employees, in the event of deletion of one or more employees.

What happens if you wish to cancel a member

Cancellation of a member shall be entertained only if supported by valid reasons and supporting documents to prove the same. AXA reserves the right to determine if the

member can be allowed to be cancelled or not. If a request for cancelation for an employee/principal is received, then his/her dependants under the same policy shall automatically be canceled. No refund shall be permissible if any claim, however small is made by the concerned member being deleted – subject to evaluation of reasons for deletion. Refund if any admitted shall be considered only 90 days after the deletion date.

A family member from an individual policy shall not be allowed to be deleted unless there is proof that the member is no longer eligible for coverdue to change in residency status for example.

Just as an employer cannot decide which employees to be offered cover under the Group cover and has to offer cover to all employees, similarly under an individual policy the principal needs to enroll all the dependants, if eligible and this would not be by choice.

Note: We will make an administrative charge of no less than 20% of the annual premium for any cancellation to which we agree. Please also note that no claim of any kind will be considered after notification by you and acceptance by us of any cancellation.

For group policies where the number of employees (absolute minimum six) determines eligibility for a discounted group premium we reserve the right to apply a minimum premium requirement reflecting that number of employees, in the event of deletion of one or more employees.

What this membership agreement means

This document sets out the terms of your membership agreement with us and must be read in conjunction with any supplementary documentation we provide to you from time to time (e.g. your membership statement including your Benefit Table, any Group Summary Benefits Table, your membership card and International Emergency Medical Assistance terms). We have tried to keep this as simple as possible however, if there is anything you do not understand or would like to clarify, please contact us. Decisions regarding your benefits and/or changes to the terms of your membership agreement cannot be made verbally but must be confirmed by us in writing. We may record calls for your protection in the event of subsequent query or for training purposes.

In this insurance document you will find detailed definitions, terms and exclusions which form part of the contract between us. Please read them carefully and ask us if there is anything you do not understand.

7 Definitions

Some words and phrases have special meanings. These meanings are set out below. When we use these terms they are in bold print.

Area/area of cover

One of the following:

- **Area 1:** Worldwide
- **Area 2:** Worldwide excluding the USA.
- **Area 3:** Arabian Gulf Cooperation Council (A.G.C.C.) member countries being Saudi Arabia, Kuwait, Bahrain, Qatar, UAE and Oman plus Iran, Lebanon, Jordan, Syria, Egypt, India, Pakistan, Sri Lanka, Bangladesh, Korea, the Philippines, Indonesia, Nepal & Bhutan.
- **Area 4:** Your principal country of residence being one of the Arabian Gulf Cooperation Council member countries being Bahrain, Qatar, UAE and Oman.
- **Area 5:** Your principal country of residence being one of the Arabian Gulf Cooperation Council member countries being Bahrain, Qatar, UAE and Oman plus your home country being any one of India, Pakistan, Sri Lanka, Bangladesh, The Philippines, Nepal & Bhutan.

Area of residence

Normally the United Arab Emirates, Oman, Qatar or Bahrain or your principal country of residence as defined in (Principal country of residence, page 13).

Benefits table

The table applicable to your plan showing the maximum benefits we will pay for each member.

Chronic

A medical condition or episode of ill health which persists for a long period or indefinitely.

Company

Your employer and/or sponsor.

Company agreement

An agreement we have with the company which allows you to be registered as the policyholder. That agreement sets out who can be covered, when cover begins, how it is renewed, and how the premiums are paid.

Currency

The currency, United Arab Emirate Dirhams, Bahraini Dinars, Omani Rials or Qatari Riyals in which claims reimbursed to the member will be paid and in which premiums must be paid.

Enrolment/time of enrolment

With effect from 23:59 hours on the date that a member is accepted by us and premium for the member's plan has been received and accepted by us. Any anniversary at which we have accepted the member under the conditions applicable at that time.

Family member

Your partner and your unmarried children (or those of your partner) living with you when you take out the policy or when it is renewed. By partner we mean your husband or wife with whom you live permanently. Children cannot stay on your policy after the renewal date following their 21st birthday.

Group

When the person paying the premium for the policy is not the member benefiting from cover under the plan and is not a family member. Normally this will be the member's employer or sponsor.

Hospital

Any establishment which is licensed as a medical or surgical hospital clinic, specialist centre or provider in the country where it operates and which is recognised by us.

Hospital beds directory/directory of hospitals/ direct billing network list

A document we publish in which those hospitals with which we have direct settlement facilities are shown. Policyholders should use a hospital listed in the hospital beds directory except in the case of emergency where this may not be possible.

Lapse

The termination of cover.

Lifetime

The period in which the member is alive. This does not refer to the life of the policy.

Medical condition

Any disease, illness or injury, including psychiatric illness.

Medical practitioner

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

Member/policyholder

You and any family member included in your policy.

Notice of Cancellation at Anniversary Date

Unless we and/or you have agreed before the end of the year to renew the policy, cover will cease on the anniversary date. This will happen whether or not written notice of cancellation has been given by us to you.

Nurse

A qualified nurse who is registered to practice as such where the treatment is given and is recognised by us.

Physiotherapist

A person who is qualified and licensed to practice as a physiotherapist where the treatment is given and who is recognised by us.

Plan

Any plan in the AXA Insurance (Gulf) B.S.C.(c) plan range.

Policy

The insurance contract between you and us. Its full terms are set out in the current versions of the following documents as sent to you from time to time:

- any application form we ask you to fill in.
- these terms and the benefits table setting out the cover under your plan.
- your membership statement and our letter of acceptance.
- the hospital beds directory or list of hospitals which you may use if such a list is attached to this document as part of a group contract. When such a list is attached to a group contract it will take precedence over the hospital beds directory.

Changes to these terms must be confirmed in writing and we will write to you to confirm any changes, undertakings or promises that we make.

Prescription

Out-patient drugs and dressings as prescribed by a medical practitioner for the treatment of a medical condition covered by the member's policy.

Principal country of residence

The country where you live or intend to live for most

of the year being 185 days or more and which will be shown as your address and place of residence in our records.

Schedule of procedures

A document we maintain which lists the surgical procedures we pay benefits for and classifies them according to their complexity.

Surgical procedure

An operation or other invasive surgical intervention listed in the schedule of procedures.

Treatment

A surgical procedure or medical procedure carried out by a medical practitioner. This includes:

- diagnostic procedures – consultations and investigations needed to establish a diagnosis.
- in-patient treatment – treatment at a hospital where the member has to stay in a hospital bed for one or more nights.
- daycare treatment – treatment at a hospital, daycare unit or out-patient clinic where the member is admitted to a hospital bed but does not stay overnight.
- out-patient treatment – treatment at an out-patient clinic, a medical practitioner's consulting rooms or in a hospital where the member is not admitted to a bed.

United Kingdom

Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

Visit

Each separate occasion that the member meets with a medical practitioner and receives a consultation and/or treatment for a medical condition.

We/us/our

AXA Insurance (Gulf) B.S.C(c).

Year

Twelve Gregorian calendar months from when your policy began or was last renewed unless we have agreed something different with the company.

You

The policyholder named on your membership statement (in the case of large group schemes this may be each member on a list of members agreed with the company or the company itself).

8 What we pay for

1. This policy insures the members against the cost of necessary treatment carried out by a medical practitioner. However, we will pay only:

   a) for charges actually incurred for items listed in your benefits table subject to the limits shown there. Note: if you incur costs in excess of the limits you will have to pay the difference;

   b) for treatment of a medical condition which is commonly known to respond quickly to treatment. When the medical condition has been stabilized we may stop making payments. We reserve the right to determine when a medical condition has become chronic or recurrent in nature;

   c) if the charges made by the medical practitioner, laboratory or other such medical service, are at the level customarily charged by medical practitioners generally for the services received. If necessary we can delay paying the claim until we are satisfied that the charges are appropriate. If the charges made by the medical practitioner, are higher than is customary we will only pay the amount which is, in our experience, customarily charged and the member will have to pay the rest;

   d) for treatment by a suitably qualified physiotherapist, chiropractor, osteopath, homeopath, acupuncturist recognised by us or for the services of a nurse if the plan covers it and then only as allowed by the benefits table;

   e) provided the costs are not for something excluded by the terms of this policy;

   f) for costs incurred during a period for which the premium has been paid;

   g) treatment of conditions that existed prior to inception of this plan/Scheme except where such treatment relates to a condition that has previously been excluded or subject to a moratorium by AXA Insurance or any previous insurer and such exclusion or moratorium has not expired; or as allowed for by your plan;

   h) the initial diagnosis and stabilization of a chronic condition (a medical condition that does not respond quickly to treatment or recurs) arising after policy inception.

      Stabilization means that, in the event of such a medical condition entering an acute phase (flaring-up), treatment to return the condition to a stable state will be covered.

      However we will not pay for routine, long term maintenance aimed at controlling and monitoring

the condition once stabilized such as routine consultation and/or medications whether or not these are prescribed by a medical practitioner unless allowed for by the benefits table and accepted by us in writing;

i) Prescriptions, being out-patient drugs and dressings as prescribed by a medical practitioner for the treatment of a medical condition covered by the member's policy provided that this cover is included in your plan.

Please note that we do not pay for standard toiletries such as, but not limited to, shampoos, soaps, tooth-pastes, contraceptives, proprietary headache and cold cures, vitamins (even if prescribed) etc. which may be bought over the counter, without prescription, at a local pharmacy nor do we pay for telephone calls or media services.

Please also note that we do not pay for minerals, herbal remedies and other dietary supplements except as part of your alternative therapy and only when we recognise these as legitimate treatments.

2. If treatment is received in United Arab Emirates, Saudi Arabia, Bahrain, Oman, or Qatar we will normally only make direct settlement payments for charges made by, or incurred in, a hospital listed in the hospital beds directory or your list of hospitals attached to this document (as defined in hospital and hospital bed, page 15). If it is medically necessary to use another hospital and we have specifically agreed, in writing, to its use before the treatment begins (and we will not unreasonably refuse to agree) we will try to arrange direct settlement facilities. Please be aware that some providers refuse to entertain such arrangements.

   We will only pay the hospital accommodation charges associated with the treatment up to a reasonable level. i.e. the use of a single-bedded room with its own bathroom.

9 What we do not pay for (exclusions and limitations)

1. We do not pay for the following:
   a) treatment of any medical condition (and its associated medical conditions whether diagnosed or not) which the member already had when he or she joined and which you should have told us about but did not tell us at all or did not tell us everything unless we had agreed otherwise in writing that there was no need for you to tell us.

      This includes any medical condition or symptoms whether or not being treated and any previous medical condition which recurs or which the member should reasonably have known about even if he or she has not consulted a medical practitioner;

   b) non-surgical treatment of a medical condition which does not respond quickly to treatment or which continues or recurs unless allowed for by the benefits table and accepted by us in writing;

   c) the monitoring of a medical condition once it has been stabilized unless allowed for by the benefits table and accepted by us in writing;

   d) any surgical procedure which is not listed in the schedule of procedures, unless we have agreed, in writing, beforehand;

   e) any treatment which only offers temporary relief of symptoms rather than dealing with the underlying medical condition;

   f) normal pregnancy or childbirth (delivery) unless this is specifically included in your benefits table - but we will pay for treatment of a medical condition which is due to and occurs during the pregnancy or childbirth except caesarean section. Caesarean section and any complication related to it is not covered unless your plan provides for 'Delivery' and this is not limited by any waiting period applicable to your plan. In this event Caesarean section and any related complications will be covered under the 'Delivery' benefit and subject to the limit shown there. We will not pay for treatment of any medical condition that arises during pregnancy or childbirth (delivery) if the pregnancy was a result of any form of assisted conception including artificial insemination. We will send you a list of the medical conditions we pay for if you ask us;

   g) treatment begun, or for which the need had arisen, during the first 90 days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination;

   h) termination of pregnancy or any consequences of it;

   i) investigations into and treatment of infertility, contraception, assisted reproduction,

sterilization (or its reversal) or any consequence of any of them or of any treatment for them;

j) treatment of impotence, sexual dysfunction or any consequence of them;

k) treatment of sexually transmitted diseases or any consequence of it;

l) treatment which arises from or is directly or indirectly made necessary by a sex change;

m) treatment of any medical condition which arises in any way from HIV infection;

n) treatment of obesity or any medical condition which arises from, or is related to, obesity in any way including but not limited to the use of gastric banding or stapling, the removal of fat or surplus tissue (including lipoma) from any part of the body whether or not needed for medical or psychological reasons;

o) the costs of collecting donor organs for transplant surgery or any administration costs involved even if such transplants are allowed by the terms of this plan;

p) treatment which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide;

q) treatment which arises from or is in any way connected with alcohol abuse or drug or substance abuse or any addiction;

r) any treatment to correct long or shortsightedness;

s) treatment directed towards developmental delay in children whether physical or psychological or learning difficulties;

t) preventive (i.e.: prophylactic) treatment;

u) vaccinations and routine or preventative medical examinations (other than health screens as allowed for by your plan), including routine follow-up consultations;

v) the costs of providing or fitting any external prosthesis or appliance;

w) out-patient drugs or dressings except those defined in 8.1 (i), prescriptions, and where your policy provides this cover;

x) orthodontics, periodontics, endodontics, preventative dentistry, and general dental care including fillings, no matter who gives the treatment unless provided for by your plan and agreed, in writing, by us;

y) claims in respect of treatment received outside the area of cover or if the member travelled against medical advice even inside the area of cover;

z) i) Professional sports – Any treatment costs incurred as a result of engaging

in or training for any sport for which you receive a salary or monetary reimbursement,

including grants or sponsorship (unless you receive travel costs only).

ii) Dangerous sports – Treatment of injuries sustained from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hangliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.

aa) any treatment specifically excluded by the terms shown on your membership statement or the schedules forming part of this Agreement;

ab) any charges which are incurred for social or domestic reasons or for reasons which are not directly connected with treatment such as but not limited to standard toiletries, shampoos, soaps, tooth-pastes, contraceptives, proprietary headache and cold cures, vitamins (even if prescribed) etc. which may be bought over the counter, without prescription, at a local pharmacy nor do we pay for telephone calls or other media services;

ac) any charges from health hydros, spas, nature cure clinics (or practitioners) or any similar place, even if it is registered as a hospital;

ad) any claim or part of a claim in respect of which you have to pay an excess (or deductible or co-insurance). In this case we will only pay the balance of the claim after we have deducted the excess (or deductible or co-insurance) amount;

ae) in-patient or daycare treatment in United Arab Emirates, Saudi Arabia, Bahrain, Oman, or Qatar unless as defined in clause 8.2 above;

af) in-patient, daycare or out-patient treatment in United States of America unless allowed for in your plan;

ag) in-patient charges for any hospital which are unreasonable or excessive. We will pay only for the reasonable cost of a single bedded room with its own bathroom as the accommodation charge associated with the treatment given;

ah) any charges for treatment related to and/or the correction of congenital

conditions and/or deformities whether or not manifest and/or diagnosed or known about at birth.

ai) any charges for treatment required as a result of any illegal action on the part of the member requiring treatment;

aj) any charges for medical reports, registration or admission fees of any kind;

2. Special terms apply in the following cases.

We will not pay benefits for:

a) cosmetic (aesthetic) surgery or treatment, or any treatment which relates to or is needed because of previous cosmetic treatment. However we will pay for reconstructive surgery if:

i) it is carried out to restore function or appearance after an accident or following surgery for a medical condition, provided that the member has been continuously covered under a plan of ours since before the accident or surgery happened; and

ii) it is done at a medically appropriate stage after the accident or surgery; and

iii) we agree the cost of the treatment in writing before it is done.

b) any dental procedure unless provided for by your plan. However, we will pay for some surgical procedures which need to be carried out by an oral and maxillofacial surgeon. We will send you a list of these procedures if you ask us.

c) special nursing in hospital and/or any nursing at home unless we have agreed in writing beforehand that it is necessary and appropriate.

d) hormone replacement therapy, except when it is medically indicated (rather than for the relief of physiological symptoms), when we will pay for the consultations and for the cost of the implants or patches (but not tablets). We will only pay benefits for a maximum of 18 months from the date of the first consultation.

e) in-patient rehabilitation except when:

- it is an integral part of treatment; and
- it is carried out by a medical practitioner specialising in rehabilitation; and
- it is carried out in a rehabilitation hospital or unit which is recognised by us; and
- the costs have been agreed, in writing, by us before the rehabilitation begins.

We will not pay for in-patient rehabilitation for more than 28 days except in cases such as in severe central nervous system damage caused by external trauma.

f) treatment which has not been established as being effective or which is experimental. However we will pay if, before the treatment begins, it is established that the treatment is recognised as appropriate by an authoritative medical body and we have agreed in writing, with the medical practitioner, what the fees will be.

3. We will not pay benefits for more than 100 days in total in any member's lifetime for inpatient treatment of psychiatric illness.

4. We will not pay for any treatment, or for international emergency medical assistance, if they are needed as a result of nuclear contamination, biological contamination or chemical contamination, whilst engaging in or taking part in war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any similar event to one of those listed.

   Please note, for clarity: There is cover for treatment required as a result of a terrorist act providing that terrorist act does not result in nuclear, biological or chemical contamination.

5. We will not pay benefits for any treatment if we have not received a properly completed claim form and original invoices within 90 days of the treatment being given.

6. We will not pay benefits for any treatment needed as a result of work related accident or injury where the cost of such treatment is normally recoverable under Workman's Compensation, G.O.S.I or similar Government Act prevailing at the time of injury or accident. You must advise us if any claim is work related.

7. We will not allow members to upgrade their level of cover except at each policy anniversary and only then when requested, in writing, to do so. Acceptance by us of such an upgrade must be confirmed in writing by us before the upgrade can become effective.

8. We will not pay upgraded benefit levels for treatment of any medical condition which arose or should reasonably have been foreseen by the member prior to the upgrade becoming effective. Members are required to declare any such medical condition to us when requesting the upgrade. Where such a medical condition is, or becomes, apparent benefits for such a medical condition will be restricted to the level of cover that would have been applicable to such a medical condition prior to the upgrade.

9. All healthcare services for internationally and/or locally recognized epidemics/pandemics.

10 Making claims

Please refer to page 4 for details of how to make a claim.

1. Before we can consider a claim you must ensure that:
   - the member sends us a completed claim form as soon as they can and no later than 90 days from the date the treatment starts; and
   - we receive original invoices for treatment costs; and
   - the member promptly gives us all the information we request.
2. The member must tell us on the claim form if they think any of the cost can be claimed from anyone else or under another insurance policy or source (such as but not limited to Workman's Compensation or G.O.S.I or motor insurance policy). If so, then:
   - if another insurance policy is involved we will only pay our proper share; or
   - if benefits are claimed for treatment to a member whose injury or medical condition was caused by some other person (the "third party"), we will pay only those benefits the member can claim under the policy (unless these are covered by another insurance policy, when we will only pay our proper share of the benefits). However, in paying those benefits we obtain both through the terms of the policy and by law a right to recover the amount of those benefits from the third party. In this case the following shall apply:

   i) you must tell us as quickly as possible that the injury or medical condition was caused by, or was the fault of, a third party. We will then send you a form on which the member can give us full written details.

   ii) if you or the member is making a claim, or has not made (or refuses to make) a claim against the third party, you or the member must act in good faith and do all the things we shall require to ensure that monies are recovered from the third party and are repaid to us up to the amount of the benefits we have paid (and any interest). You will be asked to sign a written undertaking to this effect; and

   iii) if you or the member do not repay to us monies recovered from the third party up to the amount of benefits (and any interest), we shall be entitled to recover the same from you and/or the member.
3. We can appoint and pay for an independent medical practitioner to advise us on the medical issues relating to any claim. If required by us the independent

medical practitioner will also medically examine the member making the claim and provide us with a report. The member must co-operate with the independent medical practitioner otherwise we will not pay the claim.

4. If a member makes a claim which is in any way dishonest:
   - we will not pay any benefits for that claim; and
   - if we have already paid benefits for that claim before we discovered the dishonesty we can recover those benefits from you (the member and/or the company); and
   - we can take any of the actions listed in paragraph 13.2.
5. Claim costs incurred in any currency other than United Arab Emirates Dirhams, Bahraini Dinars, Omani Riyals or Qatari Riyals will be converted using the closing mid-point exchange rate published in the Financial Times Guide to World Currencies current when we assess the claim. If we agree, in writing in advance, to reimburse benefits to a member in a currency other than those above the exchange rate used will be as above.

   Any exchange costs incurred will be payable by the member and will be subtracted from any payment made to the member in respect of such a claim.

11 Joining, renewing and transferring

Please refer to AXA Insurance for details of how to change your policy.

1. We will tell you in writing the date your policy starts and any special terms which apply to it. We can refuse to give cover and will tell you if we do.
2. Your policy is for one year unless we have agreed something different with the company, where this policy applies to a group contract. At the end of that time, provided the plan you are on is still available, you or, where this policy applies to a group contract, the company can renew it on the terms and conditions applicable at that time. You will be bound by those terms. However, we reserve the right to refuse to accept you as a customer or to renew your policy at any policy anniversary.
3. Only those people described in the company agreement where this policy applies to a group contract can be members of this plan. All cover ends when you stop working for the company or if the company decides to end the cover.
4. If your cover under a company agreement comes to an end you can apply to transfer to another plan.
5. Members of this policy who leave a company's group medical scheme may apply to AXA Insurance for an individual policy. In all such cases the member will be required to complete a new application form and make a full medical history declaration in respect of each and every person to be insured. The insurer reserves the right to apply any exclusion clauses and/or special terms it may deem necessary to any existing and/or pre-existing medical conditions at the date of application even if such conditions were previously covered under the company's group medical scheme. Please refer to page 9 if you wish to transfer to a policy that is not provided by AXA Insurance.

When the terms of your policy might change

We do not intend to change the terms of your plan during the policy year however we do have the right to cancel or change all or any part of your policy from any renewal date.

We will generally make adjustments only to reflect any past or foreseeable changes in medical practice or procedures and the type and frequency of claims made by all those of our members covered under the same plan as you.

The purpose of such changes will be to seek, as far as possible, to maintain substantially the same level and type of cover in place while ensuring that the plan remains affordable.

We may also change premiums if costs, taxation, regulations or benefit changes make this necessary.

In the event that we are required by law to make a change during the policy year, for example if a new tax is introduced, we will be obliged to do so before the next renewal date.
We do reserve the right to apply underwriting terms to your policy at any time if a medical condition that should reasonably have been declared comes to our attention, a chronic condition manifests itself within an excluded period or a medical condition becomes chronic in nature during a policy year.

12 What we expect from you

1. You must make sure that whenever you are required to give us information all the information you give is true, accurate and complete. If it is not then we can set the policy aside or apply different terms of cover.
2. This policy is designed for people living in the United Arab Emirates, Kingdom of Bahrain, Sultanate of Oman and the State of Qatar. You must tell us if a member changes their principal country of residence even if they are staying in the same area. If you don't tell us we can refuse to pay benefits.
3. You (or the company, where this policy applies to a group contract) must pay your premium when it is due. We will decide the amount at the start of each year and tell you how much it is. You can pay it in the way you have agreed with us. As your policy runs for a year you must pay your premium for the whole year no matter how it is paid. If your premium payments are not up to date your policy will end.
4. You (the member or the company) must write and tell us if you change your address. You are acting on behalf of any member covered by your policy so we will send all correspondence about the policy to the company address or that of the member.
5. If there is a dispute between you and us we have a complaints procedure, set out on page 27, which the company or member must follow so that we can resolve it.

13 General

1. We can change all or any part of the policy including the benefits table or these terms, but only for the reasons shown in our handbook or Agreement, and the changes will only apply to you when you renew unless we are obliged by law to apply any change with immediate effect. We will give you reasonable notice of the changes and will send details of them to the address we have for the company or the member on our records.

   The changes will take effect from when you renew or when applied by law even if, for any reason, any member does not receive details of them.

2. If any member breaks any of the terms of the policy or makes, or attempts to make, any dishonest claim, we can:

   - refuse to make any payment; and
   - refuse to renew your policy; or
   - impose different terms to any cover we are prepared to provide; or
   - end your policy and all cover under it immediately.

3. This policy is governed by the law of the country in which it was issued being the United Arab Emirates, Kingdom of Bahrain, Sultanate of Oman or the State of Qatar. If the principal country of residence for the policyholder or, for a group contract, the company office administering the policy is in our records; in the United Arab Emirates then Emirati law will apply; in the Kingdom of Bahrain then Bahraini law will apply; in the Sultanate of Oman then Omani law will apply; in the State of Qatar then Qatari law will apply; regardless of the location of any individual member at any time.

4. We do not pay for medical reports.

5. The terms of your policy cannot be changed nor claims authorization given by any verbal communication between you and us. Any changes, approvals, or other statements relating to your policy must be confirmed, in writing, by us. We are not bound by any verbal commitment not confirmed by us in writing.

6. AXA Insurance may be required to apply legitimate international sanctions to this policy. In such a case AXA Insurance may be unable to meet its full obligations under the terms of this policy where to do so would render it subject to legal action under international or domestic law.

14 Complaints Procedure

At AXA, we are committed to providing you with the highest level of customer service. We also realise that from time to time, things can go wrong. If this happens, we would like to hear about it. Usually, we can resolve most issues or queries immediately, so please contact our call centre, or visit your local AXA branch. However, if you feel your issue requires escalation, please raise a formal complaint below.

Our commitment to you

When you submit a complaint we will contact you within one working day to acknowledge your complaint and provide you with your complaint reference number. We will also explain the next steps in the process and provide you with details on how you can contact us to discuss your complaint.

We will endeavor to complete our investigation and share with you the outcome of your complaint within 7 working days (or 5 working days for Bahrain Life Policy compaints). If this is not possible, we will let you know and keep you updated throughout the process.

Your complaint will always be treated fairly and confidentially. Once your issue has been resolved, your feedback will be used to help us understand how we can improve.

If you're not happy with the handling or response to your complaint

If you are dissatisfied with our final response or dissatisfied with any delay in our response, you may refer your complaint to the Insurance Regulator.

You may do so by sending details of your complaint, stating the AXA Complaint Reference Number, to the relevant Regulator:

For Dubai Health Insurance complaints, you can contact the Dubai Health Authority (DHA) using the online complaint form or the details below:

E-Mail:
wasselsotak@dha.gov.ae

Toll Free (24/7):
800342 (800 DHA)

For Abu Dhabi Health Insurance complaints, you can contact the Health Authority of Abu Dhabi (HAAD) using the following details:

Email:
contact@abudhabi.ae

Telephone:
+971 2449 3333 or
Local Toll Free Number:
800 555

For Bahrain Insurance Policies, you can contact the Central Bank of Bahrain (CBB) using the online complaint form or the following details

Telephone:
+973 1754 7777

For Sultanate of Oman Insurance Policies, you can contact the Capital market Authority (CMA) using the following details

Email:
info@cma.gov.om

Telephone:
00968 24823100

For Qatar Insurance Policies, you can contact the Qatar Financial Centre Regulatory Authority (QFCRA) using the following details

Email :
complaints@cdrs.org.qa

Telephone:
+974 4495 6888

15 Your customer charter

As a valued customer of AXA Insurance you have important rights and entitlements. You are entitled to expect:

Courtesy

Your requirements will always be dealt with promptly, considerately and courteously.

No customer query is too trivial or too much trouble to sort out.

Helpful advice and guidance

AXA Insurance staff will help you, if you have any doubts, to understand the terms of your contract and any other factors which affect your cover. They will help you to make proper use of your cover should you need to make a claim.

Confidential handling of your personal details and affairs wherever possible

Any medical details we require will always be kept confidential if possible. AXA Insurance may be required to provide information regarding claims you make or have made in the past or other details you have given us to your sponsor or employer or a government department if they are paying for all or part of this policy or are entitled by law to require this of us. No liability will be accepted by us for any outcome resulting from the provision of such information to any of the aforementioned parties.

Advance notification of change in cover

Essential changes to the terms of the cover (including benefits, premiums and your membership agreement) will be notified to you, in writing, in advance of the date from which the changes take effect.

Professional and efficient service

All requests for assistance and any claims you submit will be considered impartially (without any bias or preference) in accordance with the benefits and membership agreement of your plan.

For further information contact:

AXA Insurance

P.O. Box 32505

Dubai, UAE

Telephone:
+971 (4) 429 4000

Fax: +971 (4) 429 4099

For all customer service inquiries you can contact us on:

UAE
800 2926

Qatar
800 2921

Bahrain
800 010 60

Oman
800 702 92

Our Branch locations:

UAE

AXA Insurance (Gulf) B.S.C (c)
2nd Floor, Bldg. 7, Dubai Outsource Zone, Manama Street (off Academic City Road),
P. O. Box 32505, Dubai, United Arab Emirates

Qatar

AXA Insurance (Gulf) B.S.C. (c) QFC Branch

Corporate Office
QFC Tower 1, West Bay, Office No. 604, 6th Floor, PO Box 15319, Doha, Qatar

AXA Insurance (Gulf) B.S.C. QFC Branch

Retail Sales Office

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