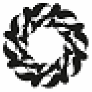

RAK LIFE INSURANCE
A division of Ras Al Khaimah National Insurance Company P.S.C.

Date	2/7/2017
Policy Number	02/DHA/2017/4345
Policy Holder	ST. THOMAS ORTHODOX CHURCH
Period of Insurance	08/06/2017 **To** 07/06/2018

Dear Customer,

Thank you for choosing RAK Insurance as your preferred insurance provider. Attached are your policy documents. Please read the documents very carefully and keep them in a secure place. These documents consist of the policy itself or an endorsement to your existing policy, the schedule and our debit note for the total premium payment. For payment of the debit note, we have a number of payment options and they are listed below.

We have also enclosed one page marked "**Declaration of Acceptance of this Contract**".This page along with "**Shortfall Undertaking**" should be signed by an authorized person and returned to either RAK Insurance or your broker by email, post or you can visit us at any one of our branches. In the unlikely event that there is an issue with any of your policy documents or should you have any questions regarding any of the enclosed documents, please contact us and we will endeavor to resolve the issue. If you wish to make an amendment to your policy, you must notify us immediately, in writing for the cover to operate.

If we do not receive any comments from you pertaining to the policy within (10) ten days from the date of this correspondence, it will be deemed that all information, terms and conditions concerning the policy are correct, accurate and most importantly accepted by you.

Payment Options
For cheque Payments - All cheques should be issued in favour of:
RAS AL KHAIMAH NATIONAL INSURANCE COMPANY (PSC)

For Credit Card Payments - Email us at info@rakinsurance.com to request our online credit card payment form - Please DO NOT send your credit card details to this email address

For Bank Transfers -

Bank Name:	RAK BANK / National Bank of Ras Al Khaimah (PSC)
Account Name:	Ras Al Khaimah National Insurance Co. PSC
Account Number:	00220-65157-001
Branch Name:	Ras Al Khaimah
Bank Address:	P.O. Box 5300, Oman St., Al Nakheel, RAK, UAE
Bank SWIFT Code:	NRAKAEAK
IBAN:	AE310400000022065157001

عزيزي العميل:

نشكركم على اختيار **شركة رأس الخيمة الوطنية للتأمين ش.م.ع** لتكون شركة التأمين المفضلة لديكم. نرفق لكم طيه وثيقة التأمين الخاصة بكم. يرجى التكرم بقرائتها بإمعان والإحتفاظ بها في مكان آمن. تتكون المرفقات من وثيقة التأمين الخاصة بكم أو من ملحق لوثيقة تأمين سبق وأن تم إصدارها لفائدتكم (بحسب الحال) وجدول الوثيقة وإشعار للمدين بخصوص إجمالي مبلغ قسط التأمين المستحق. لسداد الإشعار للمدين المذكور أعلاه، نرجو إعلامكم بأنه تتوفر لديكم عدد من خيارات الدفع المبينة أدناه.

كما نرفق لكم طيه **"تصريح بقبول هذه الوثيقة و"إلتزام بسداد المبالغ المستحقة لشركة التامين"** للتوقيع عليها من قبلكم أو من قبل الشخص المخول بالتوقيع نيابة عنكم و إعادتها الى شركة رأس الخيمة الوطنية للتأمين ش.م.ع أو لوسيط التأمين عن طريق البريد أو بزيارة أحد أقرب فروعنا. في حال وجود أي مشكلة بخصوص مستندات وثيقة التأمين أو في حال كان لديكم أي سؤال أو إستفسار بخصوص هذه المستندات، نرجو منكم الإتصال بنا وسنقوم بما في وسعنا لحل المشكلة والرد على أسئلتكم وإستفساراتكم وفي حال رغبتم في تعديل وثيقة التأمين الخاصة بكم، فإنه يجب عليكم إعلامنا بذلك فورا وخطيا وذلك حتى يتم تفعيل التغطية التأمينية.

في حال لم نستلم أي ملاحظات من قبلكم بخصوص وثيقة التأمين ومستنداتها خلال مدة أقصاها (10) أيام من تاريخ هذا الكتاب، فإنه سيتم اعتبار جميع المعلومات والشروط والأحكام الواردة بوثيقة التأمين دقيقة وصحيحة و مقبولة بالكامل من قبلكم دون أي تحفظ.

خيارات دفع قسط التأمين:

- الدفع بواسطة شيك:
يجب إصدار جميع الشيكات لصالح: شركة رأس الخيمة الوطنية للتأمين ش.م.ع.

- للدفع عن طريق بطاقة الإئتمان:
- نرجو منكم ارسالنا بدريد الكتروينى على العنوان info@rakinsurance.com لطلب الحصول على نموذج الدفع بواسطة الائتمان عبر الانترنت نرجو منكم عدم ارسال اي بيانات ذات علاقة ببطاقة ائتمانكم للعنوان الاكترونى المذكور اعلاه

- الدفع بواسطة للتحويل البنكي:
اسم البنك: بنك رأس الخيمة الوطني/ راك بنك
اسم الحساب: شركة رأس الخيمة الوطنية للتأمين
رقم الحساب:00220-65157-001
الفرع: رأس الخيمة
العنوان: الإمارات العربية المتحدة - رأس الخيمة-شارع عمان -صندوق بريد 5300
رمز السويفت: NRAKAEAK
رمز الإيبان: AE310400000022065157001

Yours sincerely,
RAK Insurance

تفضلوا بقبول فائق الاحترام،

شركة رأس الخيمة الوطنية للتأمين ش.م.ع

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي **هاتف** ٨٠٠٧٢٥٤ **فاكس** ٩٧١٧٢٢٨٨٥٠٠+ **صندوق البريد** ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة **البريد الألكتروني** info@rakinsurance.com **الموقع** www.rakinsurance.com
Ras Al Khaimah National Insurance Company (P.S.C.) P.O. Box 506, Ras Al Khaimah United Arab Emirates T. 800 7254 F. +971 7 228 8500 E. info@rakinsurance.com W. www.rakinsurance.com

شركة مساهمة عامة تأسست سنة ١٩٧٤ برأس مال مدفوع قدره ١١٠ مليون درهم إماراتي . مسجلة لدى هيئة التأمين تحت رقم ٧ / ٨٤ بموجب القانون الاتحادي رقم ٦ / ٢٠٠٧
Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

MEDICAL EXPENSES INSURANCE POLICY

02/DHA/2017/4345

for

ST. THOMAS ORTHODOX CHURCH

Issued By

RAK INSURANCE

P. O. BOX 506
R.A.K - U.A.E.

MEDICAL DEPARTMENT

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠+ صندوق البريد ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com

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شركة مساهمة عامة تأسست سنة ١٩٧٤ برأس مال مدفوع قدره ١١٠ مليون درهم إماراتي . مسجلة لدى هيئة التأمين تحت رقم ٧ / ٨٤ بموجب القانون الاتحادي رقم ٦ / ٢٠٠٧

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C. SCHEDULE OF BENEFITS

Class Name : Enhanced EBP - Aster-2017

Plan	Enhanced EBP - Aster-2017
Area of Cover	UAE (Excluding the Emirate of Abu Dhabi & Al Ain Region). Emergency extension to UAE; Home country (Excluding USA & Canada) Covered for IP subject to UAE R&C selected Network rates and with prior-approval.
Annual Financial Limit PPPY	AED 150,000 (including any coinsurance and/or deductibles)
Number of Employees	394
Network	Amity - ASTER Out-patient treatments are restricted to clinics only In-patient treatments are restricted to hospitals only
Note	Over and above Eligibility of Cover • Accidental Death benefit Covered up to AED 50,000 per person per year. • Covered for all employees and dependents (wife & children). • Parents are excluded under this plan.
Hospital Room Type	Ward room
Eligibility of Cover	· Employees only (Dependents excluded) · Employees drawing salary less than AED 4,000/ · Employees holding valid Dubai Visas / Northern Emirate, excluding Abu Dhabi & Al Ain.
Reimbursement Claims	**Emergency** - Outside Network & Govt Hospitals (IP&OP) - Covered 100% Subject To UAE Selected Network Tarrif. **Elective** - Outside Network & Govt Hospitals (IP&OP)-Not Covered
Pre-existing & Chronic conditions (In-patient & Out-patient combined) Note: Where a pre-existing or chronic condition develops into an emergency within the 6 month exclusion period it will be covered up to the annual aggregate limit	Covered
In-patient and Day-patient	

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠ + صندوق البريد ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com

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شركة مساهمة عامة تأسست سنة ١٩٧٤ برأس مال مدفوع قدره ١١٠ مليون درهم إماراتي . مسجلة لدى هيئة التأمين تحت رقم ٧ / ٨٤ بموجب القانون الاتحادي رقم ٦ / ٢٠٠٧

Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

Room and board costs for hospitalisation	Covered	
Tests, diagnosis, treatments and surgeries in hospitals for non-urgent medical cases (prior approval required from RAK Insurance).	Covered	
Tests, diagnosis, treatments and surgeries in hospitals for emergency treatment (approval required from RAK Insurance within 24 hours of admission to the authorized hospital).	Covered	
Healthcare services for emergency cases.	Covered	
Ground transportation service in the UAE provided by an authorised party for medical emergencies	Covered	
The cost of accommodating a person accompanying an insured child up to 16 years old.	Covered	Maximum AED 100 per night
The cost of accommodation of accompanying an in-patient in the same room in cases of medical necessity at the recommendation of the treating doctor and after the prior approval of RAK Insurance.	Covered	Maximum AED 100 per night
Out –patient Benefits		
Examination, diagnostic and treatment services by authorised general practitioners, specialists and consultants.	Covered Referral Procedure: No treatment may be provided by specialists or consultants without the insured first consulting a General Practitioner licensed by DHA or another competent UAE Authority.	20% up to maximum of AED 25
Laboratory test services carried out in the authorised facility assigned to treat the insured person.	Covered	
Radiology diagnostic services carried out in the authorised facility assigned to treat the insured person (non-emergency RAK Insurance's prior approval is required for MRI, CT Scans and endoscopies)	Covered	
Physiotherapy treatment services (prior approval of RAK Insurance is required)	Covered	(up to 8 sessions per person per year)
Drugs and other medicines	AED 5,000.00 Covered up to the above annual limit subject to co-insurance for each and every prescription (restricted to a list of formulary products to be published by DHA).	
Maternity Benefits		

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠+ صندوق البريد ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com

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شركة مساهمة عامة تأسست سنة ١٩٧٤ برأس مال مدفوع قدره ١١٠ مليون درهم إماراتي . مسجلة لدى هيئة التأمين تحت رقم ٧ / ٨٤ بموجب القانون الاتحادي رقم ٦ / ٢٠٠٧

Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

Maternity Services (Outpatient ante-natal services) (requires prior approval from RAK Insurance) Note: Where any condition develops which becomes life threatening to either the mother or the new born, the medically necessary expenses will be covered up to the annual aggregate limit.	Covered 10% co-insurance • 8 visits to Public Health clinics. • All care provided by Public Health Clinics obstetrician for low risk or specialist obstetrician for high risk referrals. • Initial investigations to include: • FBC and platelets • Blood group, Rhesus status and antibodies • VDRL • MSU & urinalysis • Rubella serology • HIV • Hep C offered to high risk patient • GTT if high risk • FBS, randoms or A1c for all due to high prevalence of diabetes in UAE. • Visits to include reviews, checks and tests in accordance with DHA ante-natal care protocols. • 3 ante-natal ultrasound scans.
In patient maternity services (requires prior approval from RAK Insurance or within 24 hours of emergency treatment)	AED 10,000.00 10% co-insurance co-insurance payable by the insured. Maximum benefit AED 7,000 per normal delivery, AED 10,000 for medically necessary C-section, complications and for medically necessary termination (all limits included co-insurance).
Other Benefits	
Essential vaccinations and inoculations for new borns and children as stipulated in the DHA's policies and its updates in the assigned facilities.	Covered Only available for services administered at DHA facilities.
Preventive services as stipulated by DHA to initially include diabetes screening.	Covered Frequency restricted to: Diabetes: - Every 3 years from age 30. - High risk individuals annually from age 18.
Medical emergencies on diagnostic and treatment services for dental and gum treatments.	Covered 20% co-insurance
Medical emergencies on hearing and vision aids, and vision correction by surgeries and laser.	Covered 20% co-insurance
New born cover	Covered • Cover for 30 days from birth. • BCG, Hepatitis and neo-natal screening tests. (Phenylketonuria (PKU), Congenital Hypothyroidism, sickle cell screening, congenital adrenal hyperplasia)

www.rakinsurance.com الموقع info@rakinsurance.com البريد الألكتروني شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠+ صندوق البريد ٥٠٦ رأس الخيمة ، الإمارات العربية المتحدة
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شركة مساهمة عامة تأسست سنة ١٩٧٤ برأس مال مدفوع قدره ١١٠ مليون درهم إماراتي ، مسجلة لدى هيئة التأمين تحت رقم ٧ / ٨٤ بموجب القانون الاتحادي رقم ٦ / ٢٠٠٧
Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

D. SPECIAL TERMS AND CONDITIONS

1. Quoted premium is payable annually and in advance against the delivery of cards.
2. Quoted terms are valid for 30 days from the date of quotation.
3. The quote assumes coverage is compulsory for all active at work, permanent employees residing in UAE on valid Residence permit. No voluntary selection.
4. If Policy holder has opted to add dependents for certain category, all dependents in the category residing in UAE on valid Residence permit should be enrolled without exception in this contract from inception. No voluntary selection.
5. The scheme being offered doesn't apply to the UAE nationals eligible for Thiqa scheme.
6. The broker involved in Abu Dhabi territory based groups, should be registered and approved from HAAD.
7. Lost medical cards for replacement shall be allowed free of charge subject to liability letter from the client.
8. Original medical card should be withdrawn from the cancelled employee prior to or at the deletion date.
9. A liability letter should be signed in case of non-submission of the original medical card.
10. Medical cover shall automatically cease for deceased and terminated employees along with the dependents of the employee being deleted.
11. Enrolment of new employee or dependent shall be restricted to the following within 30 days of eligibility:
    *New employees – Official date of employment with passport and visa copies to be to be submitted
    *New spouse – Date of marriage or date of entry in UAE (whichever is later) with passport and visa copies to be submitted
    *New born child – date of birth or date of entry in UAE (whichever is later) with passport and visa copies to be submitted
12. The effective date of addition/deletion request shall be the email date or the acknowledged letter request date. All additions/ deletions should be reported as soon as possible but not exceeding 7 days for DHA compliant policies and 30 days for Non DHA compliant policies.
13. Additions/deletions shall be calculated on pro-rata basis for DHA and HAAD Compliance Policies and for Northern Emirates premium refund on deletion will be subjected to no claim (At the time of deletion claim amount will be deducted from refund premium)
14. Claims paid by RAK Insurance to medical providers for uncovered services / members related to the group policy in concern such as excess of limits or service availed by the member following his cancellation shall be debited to the policy holder. Policy holder herby confirms to pay such amounts within 30 days from notice.
15. We reserve our rights to amend terms, rates and conditions in case of risk findings reveals misrepresented or undisclosed material facts that could affect the decision of the underwriter.
16. Diagnostic test MRI, CT and Endoscopies are subject to pre-approval.
17. Claim submission within 60 day for inside UAE and 90days for outside UAE subject to 8 day notification from date of discharge for inpatient and consultation for outpatient.
18. Quoted Network is subject to periodical revision.

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠+ صندوق البريد ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com
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شركة مساهمة عامة تأسست سنة ١٩٧٤ برأس مال مدفوع قدره ١١٠ مليون درهم إماراتي . مسجلة لدى هيئة التأمين تحت رقم ٧ / ٨٤ بموجب القانون الاتحادي رقم ٦ / ٢٠٠٧
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19 Change in benefits may only take place at renewal of the policy.

20 The company reserves the right to vary the premium rates, if there is change in the total number of insured members above or below 15% during the policy year.

21 This proposal is based on the information given. Any change in the number, age, sex, nationality, benefits or category of the persons to be insured or the scope of coverage will result in recalculation of the premium rates and benefits.

22 18 years and over but below 25 years of age, having the same permanent residence under employee, and who are full time students at an accredited college or university, such children shall be dependent upon the employee for support, and registered as dependents of the employee in the records of the policy holder.

23 Members above 65 years of age would have to complete individual enrolment form, they can be considered for coverage subject to individual underwriting on special rates to be agreed on.

24 Quoted terms are subject to company being informed of any major chronic condition or major illness or any condition diagnosed to develop into major condition at inception of the policy and at addition of a member. Failure to disclose such material facts may result in claim denial.

25 All benefits are inclusive of co-insurance (if co-insurance applicable).

26 Arab countries (if mentioned) in the quote include : Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kingdom of Saudi Arabia, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Somalia, Sudan, Syria, Tunisia, Yemen.

27 South East Asia Countries (if mentioned) in the quote include: Cambodia, Laos, Myanmar, Thailand, Vietnam, Malaysia, Indonesia, Philippines, Brunei, Singapore, East Timor,Bangladesh, Bhutan, India, Maldives, Pakistan, Nepal, Sri Lanka, Maldives

28 Indian Subcontinent countries (if mentioned) in the quote include: India, Pakistan, Bangladesh, Nepal, Maldives, Bhutan, Sri Lanka, Brunei, Indonesia, Malaysia, Philippines, Singapore, Cambodia, Laos, Myanmar, Thailand, East Timor & Vietnam

29 Middle East countries (if mentioned) in the quote include: Egypt, Iran, Turkey, Iraq, Kingdom of Saudi Arabia, Yemen, Syria, UAE, Israel, Jordan, Palestine, Lebanon, Oman, Kuwait, Qatar, Bahrain, Cyprus

30 Europe (if mentioned) in the quote include: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia & Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Kosovo, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malta, Moldova, Monaco, Montenegro, The Netherlands, Norway, Poland, Portugal, Romania, Russia, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, United Kingdom, Vatican City (Holy See)

31 GCC (if mentioned) in the quote include : UAE, Bahrain, Kuwait, Qatar, Oman and Kingdom of Saudi Arabia

32 Middle East & North Africa (if mentioned) in the quote include: UAE, Lebanon, Kuwait, Syria, Kingdom of Saud Arabia, Qatar, Algeria, Bahrain, Egypt, Iraq, Jordan, Libya, Morocco, Oman, Tunisia and Yemen.

33 Extended Territory if offered is covered only for medical necessitated emergency while insured member is travelling (vacation/ business trip) subject to maximum period of 90 days in a policy year.

34 Notwithstanding any cancellation provision contained within the policy, in the event that an instalment of premium is not paid by its due date insurers shall have the right to terminate the cover afforded by the policy to the insured and other party (ies) protected thereby, whether by endorsement or otherwise, by giving of not less than thirty (30) days' notice in writing to the client or the appointed broker. Notice shall be deemed to commence from the date such notice is given by the insurers.

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠+ صندوق البريد ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com
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شركة مساهمة عامة تأسست سنة ١٩٧٤ برأس مال مدفوع قدره ١١٠ مليون درهم إماراتي . مسجلة لدى هيئة التأمين تحت رقم ٧ / ٨٤ بموجب القانون الاتحادي رقم ٦ / ٢٠٠٧
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35 Change of category is not allowed during the policy period unless the member's internal status has changed in the company like promotion or salary change. Any such change would need supporting documents like promotion letter,change in contract etc

36 The policy may be terminated at any time at the request of the policyholder, in which case the company shall be entitled to retain the premium due for the period during which this policy has been in force corresponding to the short rate scale as follows

Period of Insurance (Days)	**Refund**	***Period of Insurance (Days)***	***Refund***
300 +	0%	*90 - 119*	*40%*
270 - 299	10%	*60 - 89*	*45%*
240 - 269	15%	*30 - 59*	*50%*
210 - 239	20%	*16 - 29*	*75%*
180 - 209	25%	*1 - 15*	*85%*
150 - 179	30%	*0*	*97.5%*
120 - 149	*35%*		

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠ + صندوق البريد ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com
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E. HEALTHCARE SERVICES OUTSIDE THE SCOPE OF HEALTH INSURANCE (EXCLUSIONS)

DHA Exclusions-1

1. Healthcare Services, which are not medically necessary.

2. All expenses relating to dental treatment, dental prostheses, and orthodontic treatments.

3. Home Nursing; private nursing care; care for the sake of travelling.

4. Custodial care including
(A) Non-medical treatment services;
(B) Health-related services which do not seek to improve or which do not result in a change in the medical condition of the patient.

5. Services which do not require continuous administration by specialized medical personnel.

6. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies).

7. All cosmetic healthcare services and services associated with replacement of an existing breast implant. Cosmetic operations which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body and breast reconstruction following a mastectomy for cancer are covered.

8. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.

9. Medical services utilized for the sake of research, medically non-approved experiments and investigations and pharmacological weight reduction regimens.

10. Healthcare Services that are not performed by Authorized Healthcare Service Providers.

11. Healthcare services and associated expenses for the treatment of alopecia, baldness, hair falling, dandruff or wigs.

12. Health services and supplies for smoking cessation programs and the treatment of nicotine addiction.

13. Any investigations, tests or procedures carried out with the intention of ruling out any foetal anomaly.

14. Treatment and services for contraception.

15. Treatment, services and surgeries for sex transformation, sterilization or intended to correct a state of sterility or infertility or sexual dysfunction. Sterilization is allowed only if medically indicated and if allowed under the law.

16. External Prosthetic devices and medical equipment.

17. Treatments and services arising as a result of hazardous activities, including but not limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any professional sports activities.

18. Growth hormone therapy.

19. Costs associated with hearing tests, vision corrections, prosthetic devices or hearing and vision aids.

20. Mental Health diseases, both out-patient and in-patient treatments, unless it is an emergency condition.

21. Patient treatment supplies (including for example: elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments,) excluding supplies required as a result of Healthcare Services rendered during a Medical Emergency.

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠+ صندوق البريد ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com
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22. Allergy testing and desensitization (except testing for allergy towards medications and supplies used in treatment); any physical, psychiatric or psychological examinations or investigations during these examinations.

23. Services rendered by any medical provider who is a relative of the patient for example the Insured person himself or first degree relatives.

24. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during treatment.

25. Healthcare services for adjustment of spinal subluxation.

26. Healthcare services and treatments by acupuncture; acupressure, hypnotism, massage therapy, aromatherapy, ozone therapy, homeopathic treatments, and all forms of treatment by alternative medicine.

27. All healthcare services & treatments for in-vitro fertilization (IVF), embryo transfer; ovum and sperms transfer.

28. Elective diagnostic services and medical treatment for correction of vision.

29. Nasal septum deviation and nasal concha resection.

30. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related investigations, treatments or procedures.

31. Healthcare services, investigations and treatments related to viral hepatitis and associated complications, except for the treatment and services related to Hepatitis A.

32. Birth defects, congenital diseases and deformities.

33. Healthcare services for senile dementia and Alzheimer's disease.

34. Air or terrestrial medical evacuation and unauthorized transportation services.

35. Inpatient treatment received without prior approval from the insurance company including cases of medical emergency which were not notified within 24 hours from the date of admission.

36. Any inpatient treatment, investigations or other procedures, which can be carried out on outpatient basis without jeopardizing the Insured Person's health.

37. Any investigations or health services conducted for non-medical purposes such as investigations related to employment, travel, licensing or insurance purposes.

38. All supplies which are not considered as medical treatments including but not limited to: mouthwash, toothpaste, lozenges, antiseptics, milk formulas, food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions); and all equipment not primarily intended to improve a medical condition or injury, including but not limited to: air conditioners or air purifying systems, arch supports, exercise equipment and sanitary supplies.

39. More than one consultation or follow up with a medical specialist in a single day unless referred by the treating physician.

40. Health services and associated expenses for organ and tissue transplants, irrespective of whether the Insured Person is a donor or a recipient. This exclusion also applies to follow-up treatments and complications.

41. Any expenses related to immunomodulators and immunotherapy.

42. Any expenses related to the treatment of sleep related disorders.

43. Services and educational programs for handicaps.

DHA Exclusions-2

1) Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠+ صندوق البريد ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com
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Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

2) Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type.

3) Healthcare services for injuries and accidents arising from nuclear or chemical contamination.

4) Injuries resulting from natural disasters, including but not limited to: earthquakes, tornados and any other type of natural disaster.

5)Injuries resulting from criminal acts or resisting authority by the Insured Person.

6) Injuries resulting from a road traffic accident.

7) Healthcare services for work related illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulation of Work Relations, its amendments, and applicable laws in this respect.

8) All cases resulting from the use of alcoholic drinks, controlled substances and drugs and hallucinating substances.

9) Any investigation or treatment not prescribed by a doctor.

10) Injuries resulting from attempted suicide or self-inflicted injuries.

11) Diagnosis and treatment services for complications of exempted illnesses.

12) All healthcare services for internationally and/or locally recognized epidemics.

13) Healthcare services for patients suffering from (and related to the diagnosis and treatment of) HIV – AIDS and its complications and all types of hepatitis except virus A hepatitis.

Healthcare services outside the scope of health insurance.

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F. BENEFICIARY USER'S GUIDE

<u>How to make reimbursement claims - If applicable</u>

Please call whenever in doubt (Telephone number can be located on the back of the medical card)

Claim Center Role

- Operating 24/7 round the clock for assistance and guidance.
- Professional, well-trained staff to handle all your queries / requests.
- Issues pre-approvals as required (within minutes for out-patient).
- Fix appointments.
- Information about providers.

Medical Policy Standard Claim Procedures

1. All medical claim documents should be remitted to us within the duration specified under each category.
2. **For Reimbursement:**

   <u>Within UAE:</u>

   2.1 All documents have to be submitted within a period of 60 days from the date of the claim (being the date of the patient discharge from Hospital or the treatment date for out-patient) incurred within the UAE.

   2.2 Original supporting documents to be provided for any medical claim are:
   - Doctor's prescription with seal and stamp.
   - Completed TPA ASOAP form and duly signed by the doctor with seal.
   - Original payment invoices with breakdown in detail.
   - Medical report and discharge summary if any hospitalization and/or Surgery (if any undergone).
   - Laboratory and diagnostic reports (if any prescribed by doctor and undergone).
   - Copy of insurance card of the assured to be submitted.

   <u>Outside UAE:</u>

   2.3 All documents have to be submitted within a period of 90 days from the date of claims incurred outside UAE.

   2.4 All original supporting documents as mentioned above to be provided for any medical claim. Exclusively a medical report specifying whether the treatment was an elective or emergency treatment with the medical condition briefly explained to evaluate the extent of coverage.
3. TPA may, upon the evaluation of each case, grant or deny the coverage based on the Terms, Conditions, Limitations and Exclusion of the Policy.
4. Documents will be forwarded for TPA evaluation which extends to period of 3-4 weeks. On receipt of the evaluation sheet we proceed for the settlement of the claim.
5. **Mode of settlement for medical reimbursement claim:**

   5.1 The reimbursement will be evaluated at a rate of eighty percent (80%) only along with the deductible and/or co-participation (if any) being applied as per policy of the incurred expenses that the insured paid in a non-TPA participating provider on the basis of the Reasonable and Customary Rate (R&C) applicable at TPA Participating provider in UAE at the time of the incurred expenses.

   5.2 In all the reimbursement cases, the total approved fees and expenses cannot exceed the financial limitation as identified in the Policy Schedule.

   5.3 The reimbursement of all claims will be effected in the United Arab Emirates Dirhams (AED) or USD equivalent (converted at the exchange rate applicable at the date evidenced by the bill) whenever the insured has paid the expenses of the claim, subject of the reimbursement, in a foreign currency.

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي **هاتف** ٨٠٠٧٢٥٤ **فاكس** ٩٧١٧٢٢٨٨٥٠٠+ **صندوق البريد** ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة **البريد الألكتروني** info@rakinsurance.com **الموقع** www.rakinsurance.com

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6. **For Direct Network:**

Within & Outside UAE (For outside UAE emergency cases only)

As a standard procedure, we shall effect the payments of claims directly to the TPA Participating Provider via TPA and not by the Insured, based on a prior Approval of Coverage, and up to the limits authorized therein the Policy Schedule, except in the cases where the reimbursement procedure is applicable.

Approval of Coverage

The Approval of Coverage is a decision taken by the TPA on behalf of the RAK Insurance, to cover a healthcare service sought by the Insured; this decision may also determine the conditions and extent of the approved coverage.

Procedures of Approval

The procedures for Approval of Coverage for direct payment provided for hereinafter are only applicable when the healthcare services are sought at a TPA Participating Provider and when the following procedures are compiled by the Insured depending on the following applicable cases:

- In the cases of non-emergency admission to a TPA Participating Provider in the covered territory, whether requiring an overnight stay at the hospital or not, as defined in the Policy, the Approval of Coverage from the TPA must be secured by the Insured prior to his/her benefiting from a covered healthcare service by submitting the duly completed Claim Form either directly or through the hospital to the TPA.
- In the cases of emergency admission to a TPA Participating provider in the covered territory whereby the health status of the insured requires at least an overnight stay in the hospital, as defined in the Policy, Approval of Coverage must be requested by the Insured from the TPA either directly or through the hospital immediately upon admission.
- Prior authorization from the TPA is required for the following diagnostic / therapeutic in-patient and out-patient procedures prior to treatment.

Pre-Approval for Diagnostic / Therapeutic Procedures

- Angiography
- IVP
- Arthogram
- Mammogram
- Barium Studies
- MCU
- All Endoscopies
- MRI
- CT-Scans
- Myelogram
- Doppler Studies
- Oral Cholecystogram
- Echocardiography

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- Pap smear
- EEG
- Rubella tests
- EMG
- Stress Tests
- Excretory Urography
- Thyroid function tests
- FNAC
- Toxoplasma tests
- Holter monitoring

TPA may upon the evaluation of each case, grant or deny the Approval Coverage based on the Terms, Conditions, Limitations and Exclusions of the Policy. This decision is relayed to the Insured and/or the hospital.

7. For any assistance we have a team of medical and claims professionals at the Medical Claims Centre of the TPA where you have access on a 24-hour basis through a toll-free phone number as printed at the back of your medical card.

Claim submitted directly to TPA

1. Member with reimbursement claim should scan the document and upload to TPA's website.
2. An electronic notification for the claim submitted will be given to RAK Insurance.
3. Claims will be processed by the TPA. Once confirmed an E-claim and Electronic Bordereau (payment advice) will be sent to RAK Insurance.
4. TPA will send an SMS notification with the Member advising that the claim can now be settled through RAK Insurance.
5. RAK Insurance will settle the claim to the Member.

Claim submitted directly to RAK Insurance

1. Member submits original claims to RAK Insurance.
2. RAK Insurance will scan the document and send it to the TPA.
3. TPA will process the claim. Notification will be sent to the client that the claim has been dispatched to RAK Insurance and is not ready for settlement.
4. RAK Insurance will receive payment from the TPA and register in the system.
5. RAK Insurance will dispatch the cheque to the client.

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Your Medical Networks

Network

As per the attached list

How to use the Network:

As a RAK Insurance beneficiary you are eligible for receiving outpatient and inpatient benefits.

- Please refer to your Network list.
- Kindly identify yourself as a RAK Insurance beneficiary.
- After medical services have been rendered, please sign the medical expenses form.

When is pre-approval required?

For Out-Patient

Refer to prior approval table in section C (Schedule of Benefits)

For In-Patient

- *Emergencies:* Immediate admission upon presentation of TPA card.
- TPA to be informed within 24 hours or before discharge.
- *Regular Admissions/ Daycare:* Prior approval from Claims Center is required.
- *Elective Surgery Admissions:* 24-hour's notice is required from beneficiary or physician.

Other Services

- *Dental Benefit:* '**DB**' indicates dental coverage. Prior approval from Claims Center is required for all Plans.
- *Physiotherapy:* Prior to initiation of the first session.

Pre-approval requirements

- Physiotherapy
- Day-care / Observation
- In-patient treatment
- Non-emergency treatment outside U.A.E

Emergencies

- Within 24 hours or prior to discharge

G. DEFINITIONS

Contract Definitions

1. Contract: The Contract or insurance policy (as defined in Article 1 of Section C: General Terms and Conditions) whereby the Insurer, subject to the Application Form/s, terms, provisions, Limitations, Exclusions and other conditions provided herein, guarantees the payment of the benefits set forth in the Contract Schedule and Applicable Scope of Coverage Schedules.

2. Schedule: Two technical addenda defining and forming an integral part of this Contract:

2.1. Contract Schedule: The Schedule that specifies the specific conditions of the Contract and the Beneficiary and Insurer data. Listings of data include: Contract Party data, Effective Dates, Expiration Dates, Beneficiary' data, Enrolment Dates Specific Exclusions and related Exclusion Validity Periods, if any, Lifetime Limits when applicable, Hospitalization Class, selected Plan/Products, Premium, frequency of payment, and reference to the Applicable Scope of Coverage Schedule.

2.2. Applicable Scope of Coverage Schedule: The Schedule that designates the Plan/Products selected by the Contract holder (Coverage, Limits, Deductible Excess, Co-Participation, Priority Payer if any).

3. Beneficiary Guide: The booklet or pamphlet provided by the Insurer to the Contract holder that explains how to benefit from the Contract coverage.

4. Insurer: The entity which is responsible for the payment of healthcare expense benefits under this Contract (which is usually the Insurance Company but may be another entity) and which is duly registered and licensed to operate in the country where this Contract is issued.

5. Contract holder: The legal entity that applies for this Contract and whose Application Form has been formally accepted by the Insurer.

6. Principal: One of the Contract's Beneficiaries designated as the leading Beneficiary and to whom any Dependent included in the same Contract is associated.

7. Legal Dependents: The unmarried children of the Contract holder or Principal who are 18 years of age or younger or below 25 years of age if full-time students; the spouse(s) of the Contract holder.

8. Beneficiary: The person or persons designated by the Contract holder to received Contract proceeds. Beneficiaries may be the Enrolled Employees of the Contract holder, Legal Dependents of the Enrolled Employees, listed in the Application Form/s or included thereafter which are formally accepted by the Insurer and listed in the Contract Schedule or in any subsequent Endorsement.

9. Employee: Any person Active at Work working on full time basis for the Contract holder and being remunerated accordingly.

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Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

10. Enrolled Employee: Any Employee covered under this Contract as the result of the Contract holder's application and the acceptance of the Insurer in conformity with the Contractual procedure.

11. Active at Work: The work situation of any Employee reporting regularly and on a permanent/full time basis to his workplace and performing his usual and normal duties of his occupation in conformity with the employment conditions.

12. Category: The sub-group of beneficiaries within the group covered under this Contract and for which the Contract holder has selected per status a Product and decided upon particular considerations as specified in the Schedules and the Beneficiary's master file.

13. Application Form for Insurance (herein referred as Application Form): A signed statement of facts duly completed and signed by the potential Contract holder that may or may not include Evidence of Insurability documents which are requested by the Insurer and serve as the basis on which the Insurer conducts Underwriting and decides whether or not to issue this Contract to the potential Contract holder. Once an Insurer decides to issue this Contract, the Application Form/s becomes an integral part of this Contract and the potential Contract holder is thereafter referred to as Contract holder. There are two types of Application Forms:

13.1. Initial Application Form: The first Application Form completed by the Contract holder.
13.2. Subsequent Application Form: The form the Contract holder completes requesting the Introduction

14. Evidence of Insurability: The medical and/or non-medical documentation supplied by or obtained from the Beneficiary which is necessary for the evaluation of the Application Form during the Underwriting process.

15. Underwriting: The process of risk evaluation conducted by the Insurer which establishes whether or not to accept a potential Beneficiary for insurance; and according to what adjustments and terms. Risk evaluation is conducted through the review of the Beneficiary's completed Application Form, Evidence of Insurability and may include but not be limited to the potential Beneficiary/ies' current health status, past medical history, family medical history, occupation, age, activity, lifestyle and income. Failure of a Beneficiary to truthfully complete an Application Form may result in Contract Termination or Beneficiary Termination for accepted Contracts.

16. Pre-Existing Condition: Any Beneficiary health condition known to the Beneficiary and/or to the Contract holder that exhibited symptoms or was a consequence of Injury or Illness for which medical, Surgical and/or pharmaceutical Treatment, medical diagnosis or other advice was provided prior to the Beneficiary's Enrolment Date.

17. Declared Condition: Every Pre-Existing Condition that was declared by the Contract holder in an Application Form.

18. Undeclared Pre-Existing Condition: The non-disclosure of any Pre-Existing Conditions relating to symptoms, diagnoses, health conditions by the Beneficiary and/or by the Contract holder acting on behalf of the Beneficiaries, when completing any Application Form related to this Contract.

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19. New Illness, Surgery or Injury: Surgery and/or Illness and/or Injury not-related to a Declared Condition or to an Undeclared Pre-Existing Condition.

20. Hazardous Activity: Any activity which exposes the Beneficiary to serious Injury or Illness such as but not restricted to piloting, motorcycling, mountaineering, underwater activities using artificial breathing apparatus, parachuting hang-gliding, motor-racing, etc.

21. Substandard Terms: Special adjustments and terms that are given by the Insurer to enable coverage of persons who according to underwriting standards cannot meet the normal health or other requirements of a standard Contract. Such terms include but are not limited to Specific Exclusions, additional Premium or other limitations.

22. Exclusion: Specified conditions, Illness/es, Treatment/s, Service/s, Cause/s, circumstances or other items that are expressly stated as not covered under this Contract.

23. Specific Exclusions: The Exclusions that result from the Underwriting process, which are determined by the Insurer to be applied specifically to a certain Beneficiary.

24. Plan Exclusions: The Exclusions that are attached to a specific Plan.

25. Product Exclusions: The Exclusions that are applicable under this Contract to all Plan/Products.

26. Standard Exclusions: The combined list of Exclusions that are specified under Section E-(Exclusions).

27. Exclusion Validity Period: The specified number of days following a Contract's Effective Date where certain Contract benefits for Illnesses, conditions, Treatments, other Services and any complication arising therefrom are not covered. Validity Periods may be applied to all, some or none of this Contract's Exclusions and may or may not include a lifetime restriction on coverage in the event the Beneficiary obtains the condition during the Exclusion Validity Period.

28. Exclusion Waiver Date: The date an Exclusion's Validity Period ends.

29. Gross Premium (also referred to as Premium): The amount paid by the Contract holder for insurance coverage including applicable taxes and Underwriting adjustments, when applicable.

30. Initial Contract: The first Contract the Beneficiary enrol in.

31. Contract Period: The length of time between a Contracts' Effective Date and its Expiration Date.

32. Enrolment Date: The day (00:00 hrs local time, month and year) the Beneficiary enrols for the first time in a selected Plan/Product under this Contract; or enrols under an Initial Contract which has been renewed without any interruption or alteration. The same Beneficiary can have different Enrolment Dates for different Plan/Products.

33. Effective Date: The day (00:00hrs local time, month and year) the insurance under this Contract takes effect for the first time or takes effect for each subsequent Renewal. Healthcare expense benefits begin on the Effective Date in accordance with and subject to the terms and conditions of this Contract and any attachment/s thereto.

34. Renewal: The continuance of coverage under a Contract beyond its original Contract Period by the offer and payment of a Premium for a new Contract Period.

35. Renewal Date: The day (00:00 hrs local time, month and year) which coverage under a Contract continues beyond its original term provided that payment of a Premium for the continuance of coverage has been conducted. The Renewal date coincides with the Expiration Date of the original Contract Period.

36. Endorsement: Any Amendment to the existing Contract, usually addition or deletion of an insured or Plan/Product changes.
37. Amendment: A formal document changing the provisions of the Contract.

38. Expiration Date: The day (00:00 hrs local time, month and year) this Contract expires. Healthcare expense benefits ends on this date unless Renewal has been conducted.

39. Contract Cancellation Date: The day (00:00 hrs local time, month and year) this Contract is stopped as a result of the Contract holder's written request.

40. Beneficiary Deletion Date: The day (00:00 hrs local time, month and year) the Beneficiary's coverage is stopped as a result of the Contract holder's written request and/or in case the status of the Contract holder's Beneficiaries as defined in the Contract is no longer held, or upon the cancellation of this Contract.

41. Contract Termination Date: The day (00:00 hrs local time, month and year) the Contract is stopped by the Insurer as the result of the non-fulfilment of the Contract holder's obligations as set forth in the general terms herein.

42. Beneficiary Termination Date: The day (00:00 hrs local time, month and year) the Beneficiary's coverage is stopped by the Insurer as the result of the non-fulfilment of the Contract holder's obligations as set forth in the general terms herein or upon termination of this Contract.

43. Claim: A written demand made to the Insurer by or on behalf of a Beneficiary for the payment of medical expenses under this Contract. A Claim is submitted on claims form which is accompanied by supporting billing documentation and medical reports establishing that chargeable healthcare Services were or will be rendered to the Beneficiary and the medical reasons for the conduction of such Services including but not Limited to the History and Physical Examination Report for the Beneficiary, the medical description of the present condition, Surgical or procedure reports and discharge summary. One Claim pertains to one Episode of Care.

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Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

44. Episode of Care: All Treatment rendered within a specified time frame for a Specific Assessment. The specified time frame for an In-patient Claim is defined as the period from Provider facility admission to discharge for the same corresponding admission. The specified time frame for an Outpatient Claim is defined as the single occurrence of rendering a specific Service, usually per visit, per Treatment, per test/s, per prescription or per exam.

45. Claims Adjudication: The process of placing a Claim through a series of administrative, Contract and medical edits to determine coverage or non-coverage of a Claim as well as the determination of financial settlement parameters. Pre-requisites for Claims Adjudication are:

45.1. The retrieval of all administrative and Contract information
45.2. The submission of medical information pertaining to the Claim such as the Completed ASOAP medical and Service sections and;
45.3. When deemed applicable by the TPA Claims Centre, the History and Physical Examination Report, Pre-Operative Test Reports, Surgical Report, Procedure Report, Discharge Summary, other medical documents and signed Authorization for the Release of Medical Information.

46. Covered Claim: A Claim that is eligible to be paid in whole or in part by the Insurer according to the Claims Adjudication process and the conditions of this Contract. Covered Claims may be comprised of Eligible Medical Expenses and/or Non-Eligible Medical Expenses and may be inclusive or not of Beneficiary out-of pocket amounts such as Specific Deductible Excess, Aggregate Deductible Excess, Co-Participation and/or Priority Payer shares and/or Limits as defined in the Applicable Scope of Coverage and Contract Schedules.

47. Non-Covered Claim: A Claim that is not eligible to be paid by the Insurer according to the Claims Adjudication process and the conditions of this Contract.

48. Eligible Medical Expenses: The Medical expenses which are determined by Claims Adjudication as covered by the Contract inclusive or not of Beneficiary out-of pocket amounts such as Specific Deductible Excess, Aggregate Deductible Excess, Co-Participation and/or Priority Payer shares and/or Limits as defined in the Applicable Scope of Coverage and Contract Schedules.

49. Non-Eligible Medical Expenses: Medical expenses that are determined by Claims Adjudication as not covered by the Contract.

50. Usual, Customary and Reasonable Charges (UCR): In the Insurer's sole opinion, a charge or expense for medical care which according to the Insurer's experience with the TPA local Providers does not exceed the general level of charges being made by other Providers of similar standing in the locality where the charge is incurred, when furnishing like or comparable medical Treatment, Services or supplies.

51. Cash Indemnity: A lump sum payable to a Beneficiary in connection with Covered Claim benefits. Lump sums may be payable on:

51.1 Service basis (i.e. type of Surgery)
51.2 Specific Assessment basis (i.e. type of diagnosis) or
51.3 Per day basis

52. Priority Payer: The entity or party which is primarily liable for a Beneficiary's Eligible Medical Expenses up to the Limits specified in the Applicable Scope of Coverage Schedule. Upon completion of the Priority Payer's obligation to pay Eligible Medical Expense amounts up to the specified Limits, the Insurer then becomes liable to pay remaining Eligible Medical Expense amounts within the provisions and Limits of the Beneficiary's Contract with the Insurer.

53. Co-payer: An entity or person that participates with the Insurer in the payment of an Eligible Medical Expense according to defined percentages which are specified under the Contractual Schedule and/or Applicable Scope of Coverage Schedule.

54. Out-of-Pocket Expense: Eligible or Non-eligible Medical Expenses that must be paid by the Insured.

55. Co-participation: The portion of incurred Medical Expenses, usually a fixed percentage, the Beneficiary is obliged to pay Out-of-Pocket.

56. Limit/s: A Contract provision that sets a cap on types of Eligible Medical Expenses. Limit/s may be a:

56.1 Monetary amount per lifetime
56.2 Quantity amount per lifetime
56.3 Monetary amount per year
56.4 Quantity amount per year
56.5 Monetary amount per Claim or
56.6 Quantity amount per Claim

57. Specific Deductible Excess: The amount deducted from a Claimed Medical Expense which is specified in monetary units (i.e. 25 or 50 or 100 Dhs) and which may be applied on each Family of Service (FOS), Service (S) and/or Service Item (SI). This amount must be paid by the Beneficiary each time the FOS, S and/or SI is claimed and is deducted from the total Claim. The Insurer's payment portion is calculated on the remaining balance.

58. Aggregate Deductible Excess per Beneficiary: The accumulated amount of money relating to Eligible Medical Expenses specified in the Applicable Scope of Coverage which is paid by the Contract holder on behalf of a specific Beneficiary, in addition to Specific Deductible Excess and/or the Contract holder's Co-Participation if and when applicable during the period of this Contract.

Coverage Definitions

59. Product: The packaging of Plans that is offered by the Insurer and selected by the Contract holder in the Application Form.

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي **هاتف** ٨٠٠٧٢٥٤ **فاكس** ٩٧١٧٢٢٨٨٥٠٠ + **صندوق البريد** ٥٠٦ رأس الخيمة . الإمارات العربية المتحدة **البريد الألكتروني** info@rakinsurance.com **الموقع** www.rakinsurance.com
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60. Plan/Product: The covered Family of Benefits, Families of Services, covered Causes, Exclusions, the method of Claims handling, territorial Limits, financial restrictions that are offered by the Insurer under a given Product.

61. Family of Benefits: A grouping of one or more Family of Services into a Category which defines the healthcare Services that are covered through a Product under a given Contract (e.g. In-Patient, Out-Patient, Dental, Optical).

62. Family of Services: A grouping of Services that are medically related to each other and are attached by the Insurer to different Families of Benefits. Examples: room & board, radiology, laboratory, pharmacy, Surgery, etc.

63. Service/s: Related sub-groups of medical Service items, which comprise a given Family of Services.

64. Service Item: Individual medical Services, tests, exams, consultations or other items which may are charged during the care of a Beneficiary by a Provider. Examples: blood test, urine test, x-ray, etc.

65. Family of Cause: A general categorization of reasons that Beneficiaries seek healthcare (i.e. Injury, Illness, Maternity, etc.).

66. Cause: A term that broadly describes the reason a Beneficiary seeks healthcare, for an illness the description of the disease, for an accident the description of the accident.

67. Scope of Coverage: A pre-defined frame which sets and defines the parameters of how a Beneficiary will be covered by the insurer under a given Contract (e.g. Family of Benefits, territorial, financial limits etc).

68. Hospitalization Class: The class of room and board Service which the Contract holder has selected on behalf of the Beneficiary/ies to be applied for Inpatient Confinements and which is identified in the Contract Schedule according to the following codes:

- Class VIP Suite - Basic Level of a Private Room with sitting, sleeping accommodations for one companion
- Class A -Private room (basic level one bed room)
- Class B -Semi-Private room with 2 beds
- Ward -Room with more than 2 beds

69. Territory of Occurrence: The country where the Beneficiary's health condition required healthcare Services and where related Medical Expenses were incurred.

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70. Abroad: Any country excluding the country of Contract issuance.

71. Inpatient: Treatment, diagnostic procedures and or other types of care which are delivered to a Beneficiary in a Hospital and Medically Necessitate the Beneficiary's Confinement to a Hospital as a registered bed patient for 24 hours or more. Day-Hospital admissions are considered Inpatient.

72. Non In-patient: Treatment, diagnostic procedures and or other types of care which are delivered to a Beneficiary on an Out-patient basis.

73. Outpatient: Physician's consultation, prescribed drugs, diagnostic tests and Treatments which do not Medically Necessitate Hospitalization or specialized medical attention and care in a Hospital before, during and/or after the procedure.

74. Day hospital: Surgery, medical Treatment and/or diagnostic tests which are performed on a same day Hospital basis and require specialized medical attention and care in a Hospital, before, during and/or after the Surgery, Treatment and/or test; but do not Medically Necessitate an overnight stay in a Hospital.

75. Confinement: An uninterrupted stay for a defined period of time in a Hospital followed by discharge.

76. Hospitalization: Confinement in a Hospital for a minimum of one overnight stay for Medically Necessary Surgery, Treatment or other care related to an Illness or Injury which cannot be performed on an Out -patient basis.

77. Dental Care: All care given to the teeth or other mouth parts which is not listed under the definition "Oral & Maxillofacial Surgery" including but not limited to: clinical oral and x-ray examinations of the teeth & gums, pulp vitality tests, topical application of prophylactic substances, space maintenance, any type of filling or restoration caused from tooth decay or other reason, tooth extractions, root removals, root canal therapy, pulp capping, periapical Treatments, Services related to partial or complete dentures, bridges, dental implants, braces, retainers and orthodontic care.

78. Oral & Maxillofacial Surgery: Excision of tumours, cysts of jaws, cheeks, lips, tongue, roof, floor of mouth; Reconstructive Surgery for Accidental Injuries to a Sound Natural Tooth, jaws, cheeks, lips, tongue, roof and floor of mouth; excision of jaws and hard palate, external incision and drainage of cellulitis, incision and Surgical Treatment of accessory sinuses, salivary glands or ducts, reduction of dislocations.

79. Sound Natural Tooth: A whole natural tooth without impairment and which is not in need of any other Treatment except for the reason other than Accidental Injury. A tooth with a crown/cap/ gum disease, a partial denture, a whole denture, a tooth implant or other oral appliance is not considered a Sound Natural Tooth.

80. Reconstructive Surgery: Any operative procedure or portion of a procedure performed to restore functionality or restore appearance which was lost due to Accidental Injury or Surgery or for which proper functionality or proper appearance did not exist due to a Congenital Disease.

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81. Cosmetic Surgery: Any operative procedure or any portion of a procedure performed to improve physical appearance and/or treat a mental condition through change in bodily form.

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

83. Maternity: Pregnancy, childbirth, caesarean delivery, miscarriage, abortions, obstetrical care and/or any complications related to any of the aforementioned. This benefit provides coverage for the following Out-of-Hospital services for Pre-natal and Post-natal care:

- Physician Consultation
- Diagnostic Tests
- Pharmaceuticals
- Exclusions under this benefit: This benefit does not cover:
- Supplementary maternity-related medicines
- Antenatal screening tests such as Genetic studies, Amniocentesis, Chronic Villus Biopsy, Foetal Blood sampling (Foetoscopy, Cordocentesis), Toxoplasmosis, Listerisis

84. Illness: A disease, impairment, interruption, cessation or disorder of bodily function/s, system/s or organ/s.

85. Injury: Physical damage other than Illness, including all related conditions and recurrent symptoms which are usually caused by an Accident.

86. Accident: An unforeseen, unexpected and unintended event involving an external force or impact to the body.

87. Accidental Injury: An Accident which causes acute physical damage to a Beneficiary, excluding underlying health problems causes or Pre-Existing Conditions that may aggravate or enlarge the Injury. Accidental Injury excludes chipping or cracking of teeth which is caused by reasons other than external impact.

88. Emergency: A health condition sustained as a result of sudden, non-excluded Illness or Injury, raising a legitimate professional concern that there may be a significant medical problem necessitating Treatment (medical or Surgical) to be performed exclusively within the Territory of Occurrence which cannot be delayed and requires immediate Confinement to a Hospital followed by Hospitalization or not. Confinement must be conducted within 24 hours of the Illness or Injury onset.

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Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

Operational Definitions

89. TPA: A Third Party Administrator (TPA) is appointed to act in the name of and on behalf of the Insurer in administering this Contract. TPA interfaces with the Beneficiary through the TPA Claims Centre.

90. TPA Claims Centre: A professional Service centre operating 24 hours a day, year round, staffed with a team of medical and Claims administrative specialists to support and monitor the proper application and administration of the Contract. The TPA Claims Centre provides the Beneficiary with:

90.1 Guidance and information through telephone inquiries at no cost
90.2 Verifies eligibility, carries out Pre-admission Review, performs Concurrent Review, conducts Claims Adjudication and grants Free Access in the name and on behalf of the Insurer to the specific healthcare Service Provider under consideration

91. Free Access: The Allowed Network Provider's direct billing of Eligible Claims Expenses to the Insurer and submission of payment to the Provider by the Insurer, minus any Co-payments, Limits or other Non-Eligible Medical Expenses.

92. Access Card: A personalized card issued in the name of each Beneficiary, facilitating Free Access to the covered healthcare Services provided by the Allowed Network under this Contract.

93. Claims Form: A Claim form issued by TPA that contains:

93.1 The medical details of the Claim as documented by the Beneficiary's Physician
93.2 Listing of chargeable healthcare Services which were or will be rendered (as requested and documented by the Beneficiary's Physician)
93.3 The Claims Adjudication decision
93.4 The availability of Free Access for the Beneficiary
93.5 The coverage or non-coverage of the Beneficiary for chargeable healthcare Services and
93.6 The directions for financial settlement

94. Provider: A generic term for Physicians, Hospitals, clinics, medical centres, pharmacies, laboratories, physiotherapy centres, dentists and other paramedical institutions or persons who are licensed to offer healthcare Services.

95. Network: A group of healthcare Providers Contracted by TPA for the purpose of providing Beneficiaries with Free Access to their Services on a direct billing and Free Access basis in conformity with the terms of this Contract. Listings of Network Providers are subject to change without advanced notice and may be obtained from the TPA Claims Centre.

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Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

96. Not Allowed Network: Healthcare Service Providers that are part of the TPA Network but which are not available under a particular Product.

97. Non-Network: Healthcare Service Providers that are not part of the TPA Network.

98. Preadmission Review: The practice of conducting Claims Adjudication before the Beneficiary has the care or Service conducted. Certain drugs, supplies, Services, Confinements, etc. may require prior approval before they are covered under this Contract. Failure to obtain prior approval may result in a Non-eligible Claim.

99. Concurrent Review: The ongoing review of a Beneficiary Illness or Injury during Confinement to determine appropriateness, Medical Necessity and coverage.

100. Generic Substitution: The method of dispensing the generic version of a drug in place of the original Product.

101. Gatekeeper: A primary care Physician which screens Beneficiary cases to effectively eliminate needless referral to specialist Physicians.

102. Length of Stay: The number of consecutive days a Beneficiary is confined.

103. Deletion Date: The day (00:00 hrs local time, month and year) the Beneficiary's coverage is terminated as the result of deletion from this Contract at the request of the Contract holder.

Medical Definitions

104. Hospital: Any medical institution, public or private, which is legally licensed and provides medical treatment to sick and injured persons. The facility must consist of organized premises, possess the necessary technical and scientific equipment for diagnosis and surgical operations and should provide healthcare services 24hrs/a day by a staff of at least one resident physician and qualified professional nurses. The term "Hospital" excludes Out-patient clinics, sanitarium, physiotherapy centres, health clubs, retirement homes, nursing homes and other non-hospital institutions, including those specialized in substance abuse (drugs, alcohol).

105. Physician: Any doctor of medicine (MD) duly licensed and qualified to render Treatment provided under the law of jurisdiction in which Treatment is provided.

106. Specific Assessment: A listing of ICD9CM (International Classification of Diseases, 9th Edition-Clinical Modification) diagnoses and identifying codes used by Physicians for reporting diagnoses of the Beneficiary. The coding and terminology provide a uniform language that can accurately designate diagnoses and provide for reliable, consistent communication of such.

107. Treatment: Any Surgical, medical, pharmaceutical or other approach used to cure or rectify a Beneficiary Illness or Injury which is deemed as being Medically Necessary and which must be legally permitted in the country where the Treatment was prescribed.

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108. Surgery / Surgical: Any invasive or incisional procedure including Laser, injection therapy, electro cauterization, cryotherapy, which is used to diagnose, cure or rectify an Illness, Injury, condition, defect or malformation. In this context, invasive diagnostic procedures such as endoscopy, angiography, destruction of kidney or gallstones, any method of treating a fracture, reduction of a dislocation, normal childbirth and catheterization (excluding urethral, peripheral venous and/or arterial) will be considered as Surgery / Surgical.

109. Medically Necessary: Hospitalizations, Confinements, Surgeries, procedures, Treatments, Services, supplies, medications, equipment or other items or expenses requested, provided or charged by a Provider which the Insurer, in its own opinion determines are all of the following:

109.1 Required for the Treatment or management of an Illness or Injury
109.2 Appropriate to diagnose or treat the Beneficiary's Illness or Injury
109.3 Consistent with standards of good medical practice
109.4 Are not primarily for the personal comfort or conveniences or the Beneficiary, family or the Provider
109.5 Are not a part of or associated with the scholastic education or vocational training of the Beneficiary or primarily for education or experimental purposes.
109.6 In case of Inpatient care, cannot be provided safely on an Out-patient basis and Are given in the most cost efficient manner and setting consistent with maintaining safe care.
109.7 Legally available in the country of prescription. The fact that a Provider has prescribed, recommended or approved a Hospitalization, Confinement, Surgery, procedure, Treatment, Service, supply, medication, equipment or other item or expense does not, in itself, make it Medically Necessary.

110. Unnecessary Treatment: A Service or Treatment that is not medically necessary.

111. Chronic Disorder: A Specific Assessment that requires a regular, lifetime Treatment.

112. Release of Medical Information: A document prepared for the Provider which is signed and authorized by the Beneficiary to allow the CC on behalf of the Insurer to access all Beneficiary medical records at a given Provider. The Beneficiary's failure to sign or authorize a Release of Medical Information will result in a Non-eligible Claim.

113. History and Physical Examination Report: A report issued by the Beneficiary's Physician which details two sections of the Beneficiary's medical profile:

113.1 Section related to previous health status including history of previous Hospitalizations, previous Illnesses and Injuries, childhood diseases, allergies, medications, habits, etc. and
113.2 Section related to the Beneficiary's current Illness or Injury including date of onset, symptoms, physical examination, test results, diagnosis/es or Specific Assessment/s and planned therapy

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114. Surgical Report / Procedure Report: A report issued by the Beneficiary's Physician who describes the Surgical or procedural act and results.

115. Discharge Summary: Summary of the Beneficiary's Hospitalization course including the History & Physical Examination Report, diagnoses/es or Specific Assessment/s, complications incurred during the course of Hospitalization, therapy or Treatment which was provided, results of the Hospitalization and the discharge status of the Beneficiary including the status of the diagnosis/es or Specific Assessment/s, future medical Treatment, medications and follow-up directions.

116. Check-up: Examinations, tests, procedures, consultations or other medical services that are conducted for preventative or screening reasons and which are not related to a current symptom, Specific Assessment or other Beneficiary health problem.

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H. GENERAL TERMS AND CONDITIONS

Article 1. Insurance Policy (herein referred to as Contract)

Declaration of Acceptance, Signed Quotation / Application Form/s duly completed by the Contract holder acting on behalf of the Beneficiary, Premium Payment Schedule, List of members, Schedule of Benefits, Special Terms and conditions, Exclusions, User beneficiary guide, Definitions, General Terms and Conditions and any attachment and Endorsement to any of the aforementioned shall constitute the entire Insurance Contract between the Insurer and the Contract holder (referred to as "this Contract"). In case of any inconsistencies between the schedule of Benefits and exclusions, Schedule of Benefits shall prevail. In case of any inconsistencies between General terms and conditions and special terms and conditions, special terms and conditions shall prevail. Amendment or addition to this Contract shall be void, unless it has been made in writing and is signed and sealed by the Insurer. No Insurance intermediary has the authority to amend this Contract or waive any of its provisions.

Article 2. Contract Validity

The validity of this Contract (in regard to each Product selected) begins at the Effective Date and terminates at the Expiration Date as specified in the Contractual Schedule. However, each Beneficiary is covered under this Contract as from his Enrolment Date as specified under the Contract Schedule and/or any related Endorsement up to the Expiration Date of this Contract.

Article 3. Application Form

This Contract and its related Endorsements have been issued by the Insurer on the basis of the Contract holder's declarations. The Insurer reserves the right to reject any Subsequent Application that is not in conformity with the provisions of this Contract.

Article 4. Representation Clause

In the event that the Contract holder has provided and confirmed directly or through its appointed insurance representative, a claims experience on the basis of which the company has calculated the premium relating to this contract, the contract holder takes note that the company reserves the right to amend the premium of this contract, retro-actively form the effective date, if it has proof that the contract holder has directly or indirectly misrepresented the past claims experience. In such a case the contract holder acknowledge and agree that it shall be liable for such a premium revision, which payment to the company shall be subjected to the provisions under article 7.

Article 5. Priority Payer

In case of the participation of a Priority Payer, the Applicable Scope of Coverage of this Contract shall apply in excess of the Priority Payer's share when applicable. The Priority Payer's share is specified if any, when applicable under the Applicable Scope of Coverage Schedule.

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Article 6. Co-Payer

In case of the participation of a Co-Payer, the Applicable Scope of Coverage of this Contract shall apply on a proportional basis with the Co-Payer when applicable. The Co-Payer participation percentage is specified if any when applicable under the Applicable Scope of Coverage Schedule, the participation percentage being the balance of all the Co-Payer(s) Co-participation(s).

Article 7. Premiums

The Premium being the Gross Premium is due by the Contract holder to the Insurer as defined in the Contract Schedule are payable in advance by the Contract holder according to the frequency of payment agreed upon between the Contract holder and the Insurer and as specified in the Contract Schedule.

The coverage provided by the Insurer under this Contract shall not commence until the first instalment is fully paid.

In the event the Premium is not paid on the due date, the Insurer will notify the Contract holder of the amount payable within 30 days also informing the Contract holder that otherwise this Contract will be cancelled. If no payment is made at the end of this grace period of 30 days, this Contract will be terminated and the Contract holder will be liable for the amount due until the date of Cancellation. During these 30 days grace period, Free Access to the Allowed Network on direct billing basis shall be suspended. In the event the Premiums payment is effected by the Contract holder within the grace period of 30 days, Free Access to the Allowed Network on direct billing basis shall be reinstated and healthcare expenses incurred during the suspended period shall be processed and reimbursed on the basis of TPA Network tariff. If no payment is made at the expiry of this grace period of 30 days this Contract will be automatically terminated and the Contract holder will be liable for the amount due until the date of cancellation. The Premium payment is substantiated exclusively and solely by the issue of a relevant receipt from a legally authorized representative of the Insurer.

Article 8. Enrolment

The Contract holder has to declare in writing at the date of the initial application that all Employees of a Category are enrolled on compulsory basis. In virtue of the Contract holder declaration, this Contract was underwritten and issued by the Insurer.
In accordance with the Contract holder declaration on the Initial Application Form it is agreed and understood that all Employees without exception are to be included under this Contract.

Similarly, all Legal Dependents related to a specific Category for which the Contract holder has declared that enrolment of Legal Dependents is compulsory, are to be included under this Contract. However, Legal Dependents relating to a Category for which the Contract holder has not required and declared on the Initial Application Form the status of compulsory, cannot be enrolled under this Contract.
It is fully agreed and understood that the enrolment rules as stated under this article form one of the basics of this Contract. The non-obedience by the Contract holder to these rules shall give to the Insurer the right to terminate this Contract from Effective Date without Premium refund.

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Article 9. Addition

9.1. General Rule

The Contract holder has the right to require from the Insurer by completing and signing a Subsequent Application Form, the addition of new Beneficiary/ies.

The Insurer shall restrict the enrolment of new Beneficiary/ies which addition has been applied for by the Contract holder, to:

- New Employees.
- New Spouse in case dependents is on compulsory basis for the concerned Category.
- Newborn child or new adopted child in case dependents is on compulsory basis for the concerned Category.

9.2. Supporting Documents

Submission by the Contract holder of supporting documents relating to the required addition which are satisfactory to the Insurer are necessary for the validation of any eligible addition.

9.3. Effective Date

The Effective Date of any approved addition should match with:

For New Employee: The official date of employment in accordance with the Contract holder's House Rules.
For New Spouse: The date of marriage
For New born child: The date of birth
For New adopted child: The date of official adoption

If request for an addition is made within 10 days following the eligibility date of a beneficiary, his/her Enrolment Date will be such eligibility date. Otherwise, the Enrolment Date of a Beneficiary is the date on which the Insurer accepts such addition.

Dependents not in UAE-please note they will automatically will be included from the date of arrival in UAE subject to addition request being made within 10 days of arrival, otherwise, the Enrolment Date of a Beneficiary is the date on which the Insurer accepts such addition.

9.4. Underwriting

The initial Underwriting terms as applied on the Effective Date of this Contract shall be applied for all eligible additions which were required within a period not exceeding 30 days form the Effective Date of the required addition.
In case an addition is required 30 days after the Effective Date of this addition, the Insurer reserves the right to proceed with a different Underwriting process which may result with different Underwriting terms than the ones applied on the Effective Date of this Contract.

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9.5. Premium

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

Article 10. Deletion

10.1. General Rules

The Contract holder has the right to require from the Insurer by completing and signing a Subsequent Application Form, the deletion of Beneficiary/ies. The Insurer shall restrict the deletion of Beneficiary/ies which deletion has been applied for by the Contract holder to:

- Deceased Employees.
- Terminated Employees (Retired, Resigned, Dismissed).
- Legal Dependents of Employees eligible for deletion.

10.2. Supporting Documents

Submission by the Contract holder of supporting documents, relating to deletion request that are satisfactory to the Insurer is a pre-requisite for deletion validation. Among required documents is the Access Card of the Beneficiary which deletion is applied for.

10.3. Effective Date

The Effective Date of any approved deletion should match with one day following the date of death of the Employee or one day following the date of termination of the Employee.

10.4. Liability

The Contract holder shall be the sole and fully liable party towards the Provider(s) and/or TPA in relation with any health expenses incurred by the deleted beneficiaries as from the Effective Date of deletion. To this effect the Contract holder should make sure that the Access Card of the Beneficiary to be deleted has been withdrawn from the concerned Beneficiary prior or at the Deletion Date.

10.5. Premium

The Premium refund relating to any approved deletion shall be calculated on pro-rata basis subject to no claim and the size of the group shall not diminish by 50% at the time of deletion.

Article 11. Category

The Contract holder has declared in writing at the date of the initial application, the different categories of his group of Employees in accordance with set criteria. Each Employee shall be enrolled at the initial Effective Date or at any

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subsequent Effective Date with his/her dependents under a specific Category in full accordance with his criteria. A Beneficiary's Category cannot be changed (unless his internal status has changed in the company - promotion) during the period of the Insurance Contract.

Article 12. Amendments

The Contract holder has the right to require Amendments on the initial Contract conditions. However, any Amendment other than the ones clearly defined under article 9 and 10 shall be subject to the Insurer new Underwriting process which outcome may not be in line with the Underwriting terms applied at the Effective Date of this Contract.

Article 13. Endorsement Validity

Any addition, deletion or any other Amendment can only be considered as accepted by the Insurer when and if a relevant Endorsement is issued, sealed and signed by the Insurer.

Article 14. Experience Rating

The Insurer undertakes to renew this Contract taking into consideration the incurred Claims experience of the Contract holder as well as the global country related claims parameters.

Article 15. Claims Notification

In case of an intended or present healthcare Claim occurring at an Allowed Network or at a Not Allowed Network Provider, the Beneficiary is obliged to notify the TPA Call Centre immediately. Such notification may be conducted in writing and/or verbally 24 hours a day, 7 days a week. Subsequently, the TPA Call Centre shall provide the Allowed Network Provider with an authorization or denial form issued on behalf of the Payer. An authorization form shall result in the granting of free access to the Beneficiary at the allowed Network.
In case the Beneficiary did not obtain Free Access under Inpatient on a direct billing basis, he is required to submit a signed Release of Medical Information from the Provider where Services were rendered and all relevant medical documents such as the surgical report, history and physical, diagnostic test reports, etc. within a maximum period of eight days starting from the Discharge Date, to the address specified in the Beneficiary Guide.
In case of an Out-patient Claim occurring at an Allowed Network, the Beneficiary benefiting from Free Access, does not have to notify the Insurer.

In case of an Out-patient Claim at a Network and/or at a Not Allowed Network where the Beneficiary did not obtain Free Access on direct billing basis, he is required to submit a completed ASOAP(s), a signed release of medical information form, as well as copies of the related procedure reports, test reports, prescription or other documentation within a maximum period of eight days starting from the date on which the medical Service/s was provided, to the address specified in the Beneficiary Guide.

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Article 16. Claims Receivables

16.1. In-Patient claims

It is agreed and understood that the Inpatient Family of Benefits is limited to Eligible Expenses arising from Inpatient admissions that have admission dates occurring within the validity period of this Contract. The liability of the Insurer ceases on the date of discharge and is limited to the services rendered during the Episode of Care not exceeding 30 days past the Expiration Date of the Contract.

16.2. Non-In-patient claims

It is agreed and understood that the liability of the Insurer is limited and restricted, under this Contract, to any Eligible Expenses incurred under all Family of Benefits, with the exception of In-Hospital, which Transaction Date is within the validity of this Contract.

16.3. Prior - Authorization from the TPA Call Centre

Is required for the following diagnostic / therapeutic in-patient and out-patient procedures, prior to treatment.

Pre-Approval for Diagnostic/Therapeutic Procedures:
- Angiography
- IVP
- Arthogram
- Mammogram
- Barium Studies
- MCU
- All Endoscopies
- MRI
- CT-Scans
- Myelogram
- Doppler studies
- Oral Cholecystogram
- Echocardiography
- Pap smear
- EEG
- Rubella tests
- EMG
- Stress tests
- Excretory Urography
- Thyroid function tests
- FNAC
- Toxoplasma tests
- Holter monitoring

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Article 17. Subrogation

Once the Insurance Claim has been paid in accordance with the current terms, the Contract holder subrogates his/her right to the Insurer to pursue any third party responsible for an Injury the Contract holder and the Beneficiary transfer to the Insurer every relevant substantial and legal right. Both, the Contract holder and the Beneficiary shall provide the Insurer with every possible assistance in case the Insurer exercises the above right of subrogation. Should the Contract holder and the Beneficiary breach this obligation, they shall be responsible for any losses incurred by the Insurer.

Article 18. Cancellation

18.1. Contract holders' right

The Contract holder has the right to formally request the cancellation of this Contract from the Insurer.
In case of breach of contract by the contract holder, the Insurer has right to terminate this contract as per UAE laws and regulations.
By doing so the Contract holder shall be the sole and fully liable party towards the healthcare Providers and/or the Insurer in relation with healthcare expenses incurred by the present beneficiaries as from the Cancellation Date of this Contract.

To this effect, the Contract holder should make sure that the Beneficiary Access Cards have been withdrawn prior or at the Cancellation Date.

The Premium refund relating to the cancellation of this Contract should be condition no. 36 in Section 2 (Special Terms and Conditions).

18.2. Insurer' right

The Insurer has the right to cancel the present Contract in the following instance:
a. Proven false statements made by the Contract holder.
b. Non-Payment of due Premium 30 days after the notification as per Article 7.
c. Conditions mentioned in Section 2 (General conditions and procedures).

In case the Insurer legitimately cancels this Contract, no Premium refund shall be due to the Contract holder.

Article 19. Governing Law and Jurisdiction

This Insurance Policy shall be subject to and governed by, in its interpretation or in respect of any difference or dispute arising out of or in connection with it, to the laws and regulations of the United Arab Emirates. The competent Courts of the United Arab Emirates shall have the sole jurisdiction in case of any difference or dispute arising out of or in connection with this Insurance Contract.

Article 20. Currency

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Public Shareholding Company established in 1974 with a paid up capital of AED 110m, Registered at the Insurance Authority with registration no. 7/84 in conformity with the Federal Law No.6/2007

Any money payable to or by the Insurer shall be in Dirhams. For Treatment Abroad the amount payable shall be based on the exchange rate prevailing at the Date of Transaction.

Article 21. Change of Law

This Contract is intended to conform to the law of the country in which the Insurer home office is located. If a conflict arises between this Contract and such law becomes effective after the Contract Effective Date, the Insurer may, at its own option, re-negotiate the terms of this Contract from the date such law becomes effective.

Article 22. Duties

Any levies on the Contract, tax or stamp duty shall be borne exclusively by the Contract holder.

شركة رأس الخيمة الوطنية للتأمين الفرع الرئيسي هاتف ٨٠٠٧٢٥٤ فاكس ٩٧١٧٢٢٨٨٥٠٠+ صندوق البريد ٥٠٦ رأس الخيمة ، الإمارات العربية المتحدة البريد الألكتروني info@rakinsurance.com الموقع www.rakinsurance.com
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شركة مساهمة عامة تأسست سنة ١٩٧٤ برأس مال مدفوع قدره ١١٠ مليون درهم إماراتي ، مسجلة لدى هيئة التأمين تحت رقم ٧ / ٨٤ بموجب القانون الاتحادي رقم ٦ / ٢٠٠٧
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