

health insurance

Membership handbook

Healthcare Series - Large Corporate Plans



what you need to know

رؤية جديدة / للتأمين
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1. Welcome

We are pleased to welcome you into the protection of the International Healthcare series plan from AXA.

As part of the AXA Group, AXA Gulf has been present in the region for more than 60 years and is one of the largest insurers in the GCC with branches across Bahrain, Oman, UAE and Qatar. In Saudi Arabia AXA is known as AXA Cooperative Insurance.

Every successful company acknowledges the importance of its employees. They are not only its greatest asset, but also its most vulnerable resource. With the International Healthcare series plan from AXA Insurance, you and your family can be rest assured, that whatever the coming year brings, we'll be there to support you!

AXA is continuously striving to offer you service excellence from our 24/7 healthcare platform and manage your comprehensive healthcare plan, which has been designed by AXA Insurance in consultation with your Company.

Please note that this standard member guide is only for guidance and does not override the definitive policy agreement. You are requested to read this member guide in conjunction with your Benefits Table in order to fully understand your level of cover.

The full terms, conditions and benefits of the contract of insurance between your Company and AXA Insurance are held with your HR Department and it is the Agreement (not this guide) which fully defines your cover.

2. The Purpose of Your Cover

This standard member guide, in conjunction with your Benefits Table has been designed to outline the processes that are relevant to your plan. If there is anything you do not understand, please do not hesitate to call the Customer Service Team on the number shown on the back of your membership card.

Please take a few moments to refresh your memory about your Healthcare series plan from AXA. Then relax and look forward to the highest standards of service from AXA.

As with all insurance policies your AXA plan is there to cover you for eligible treatment costs arising from an illness or accident. 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.

At AXA we are always aware that behind every claim there is a person who needs help and assistance.

We do not decide whether the treatment you receive should be given on an in-patient, daycare or out-patient 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 the claim.

3. Planning an Admission to a Hospital

Why do I need to contact AXA?

If you need to be admitted into Hospital for a Daycare or an In-patient treatment, for an eligible planned medical treatment, please contact us before your admission so that we can discuss this with you.

The reason for this is so that AXA can:

1. Confirm that you are covered for the planned treatment;
2. Confirm how much we will pay for the planned treatment;
3. Confirm how long we will pay for you to stay in hospital;
4. Confirm whether we will be able to settle directly your hospital bills or not;
5. If necessary, advise you of hospitals in your area;
6. And if you are travelling we will be able to help you with your admission.

Going into hospital....What do I need to do?

First things first...

1. Please bring your valid AXA medical card and another form of identification, such as your passport or ID.
2. If you are intending to visit a provider, outside your designated provider network, please take an AXA claim form with you, you can print one from our web site www.axa-gulf.com.

3. Please show these documents to the clinic or hospital representative before you see a Medical Practitioner.

Remember to...

1. Remind the hospital that you are insured with AXA and ask them to confirm that they have received prior approval for your stay and treatment. You should check what our prior approval says as you may have to pay for anything not shown on that prior approval before you leave the hospital. Please contact us before admission if you have any concerns.
2. The hospital will ask you to complete an admission form . Please make sure that your insurance details are included in the form before you sign it.
3. The hospital may ask you for a credit card. This may be used to collect payment, from you, for anything that is not covered by your plan or for which the hospital has not received prior approval from us.

Whilst in hospital...

Whilst you are in the hospital, if you have any doubts about what you are being told or if you do not understand something, please do not hesitate to contact us for advice. If you are not able to contact us yourself, we will be happy to talk to someone else with your permission. Working with us to manage your care while in hospital reduces the risk of you having to pay for all or any part of the cost.

Leaving the hospital...

Before leaving the hospital you will be asked to pay for anything not covered by your policy and not included in our prior approval. If this is the case please keep all receipts for future reference. If you need any advice following your discharge from hospital please do not hesitate to contact us.

4. Prior Approval

Why does AXA Insurance require prior approval for certain treatments?

The reason we require prior approval for treatment is to protect you from unexpected costs. When issuing confirmation of cover in this way, we confirm the following:

1. The planned treatment is eligible under your policy;
2. The planned treatment is medically necessary;
3. The planned treatment is within reasonable and customary costs;
4. The planned treatment cost falls within the remaining benefit limit of your plan.

AXA will authorize the prior approval in conjunction with you, the attending medical practitioner and the provider, to ensure that appropriate solutions are being utilized.

Treatments such as (but not limited to) the following require prior approval.

In-patient and Daycare treatment

1. All In-patient and daycare admissions,
Including laboratory tests, diagnostic tests, surgery and all other medical services
2. In-patient maternity services
3. In-patient dental services
4. Psychiatric treatment

Out-patient treatment

1. For all treatment exceeding or which are likely to exceed AED 1,000, QAR 1,000, OMR 100, BD 100 or equivalent (these amounts may change depending on your country of treatment)
2. MRI, CT, PET and Gait Scans and internal diagnostics such as but not limited to endoscopy, colonoscopy, gastroscopy, etc
3. Physiotherapy services
4. Alternative/Complementary therapy services
5. Prescriptions or other medication required for more than 30 days.
6. Dental / Optical / Health screen services
7. Maternity treatment
8. Psychiatric treatment

Please note that if you do not obtain prior approval as required, it may prevent us from settling all or part of any claim. AXA pays only for treatment charges which are, in our experience, reasonable and customary depending on your level of cover.

Prior approvals are cost, time and benefit specific. If any details on the original prior approval change, such as (but not limited to) cost, time, benefit, etc; a further written prior approval should be obtained from AXA.

If the illness or injury is not covered by the policy or if the member has reached the policy limits for the benefit

the member will be required to pay any shortfall to the provider. We reserve the right to recover any such sum not thus paid, being due for ineligible treatment, from the member or the company.

When do I need to contact AXA for prior approval?

Within the designated provider network shown for your plan

When you visit a hospital or clinic within the designated provider network shown for your plan, the hospital or clinic representative will contact us directly in order to obtain a prior approval for your medical treatment (including in an emergency).

Outside the designated provider network shown for your plan

If you are visiting a hospital or clinic outside the designated provider network shown for your plan, then there is no need for prior approval with AXA, unless it is a treatment that is specifically listed as requiring a prior approval. For planned treatment, you are requested to contact us at least 5 days prior to your treatment taking place. Please contact us before your treatment if you have any concerns. You will be required to submit your claim for reimbursement as per the claims process.

Does AXA cover you for treatment outside of your area of cover?

In case the plan provides coverage outside your area of cover, this will be to cover emergency treatment, we will, in consultation with the treating practitioner, retain the right to

determine what constitutes 'emergency' treatment. This benefit does not provide cover for treatment for any condition if you have travelled outside your area of cover to get treatment which was, or may have reasonably been known about, before travel commenced. Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth.

Do I need to take prior approval in case of an Emergency within the area of cover or outside of the area of cover?

We know that in a real emergency you may not be able to contact us for prior approval before your treatment. 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 form of identification so that they can contact us immediately. In any event, under these circumstances, our prior approval 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.

Please refer to your Benefits Table for details on the coverage for an emergency arising outside your area of cover.

5. Claims Procedure

What do I need to do when I visit a Clinic/Hospital within the designated provider network shown for my plan?

As an AXA member you have the option to access many medical providers within the region and across the globe, as applicable to your plan. You will benefit from this extensive designated provider network that works with AXA to provide direct settlement facilities. This list is subject to change and you would find the latest updated list in our website.

You can search for different types of medical providers including hospitals, clinics, pharmacies, medical centres, radiology centres, dentists, optical centres and many more across the globe at:

<http://locator.axa-gulf.com>

You will be able to see the location of the medical provider and also the contact details should you need to get in touch with them. You can also create your own search list and download a PDF version that you can carry along while you plan a trip.

This means that when you receive treatment at these providers, all bills will be settled directly between the provider of the treatment and AXA, allowing you to continue your treatment with complete peace of mind without having to worry about the settlement of bills.

Please refer to the Benefits Table for the designated provider network and area of cover shown for your plan.

First things first...

1. Please bring your valid AXA medical card and another form of identification such as your passport or ID.
2. Please show these documents to the clinic or hospital representative before you see a Medical Practitioner.
3. See the Medical Practitioner, who will give you the treatment you need, any prescription you might need or refer you for further investigation.
4. At the end of this consultation you and the Medical Practitioner should complete and sign the claim form (the hospital or clinic will provide this).

NB. Do not sign an empty, incomplete or incorrect claim form.

Don't forget your deductible/co-insurance

- If your plan requires you to pay a deductible/coinsurance you must pay it before leaving the clinic or hospital. Details of this are given on your AXA medical card.

Now your medication...

- If you have been prescribed any medications, please obtain these from a designated provider network pharmacy (this may be inside the clinic or hospital itself). If not please refer to the Pharmacy Network shown for your plan.
- If you wish to use a pharmacy outside the designated provider network take the prescription with you to the pharmacy, collect your medication and a receipt. You will need to submit the receipt as shown in the claims reimbursement process.

What if the clinic/hospital is outside the designated provider network shown for my plan?

1. Please bring your valid AXA Medical card and another form of identification such as your passport or ID.
2. Don't forget to take the AXA claim form in with you when you go to see the Medical Practitioner.

The reimbursement claim form can be found on our web site www.axa-gulf.com.

3. Please see the Medical Practitioner, who will give you the treatment, along with any prescription you might need or refer you for further investigation.

4. At the end of this consultation you and the Medical Practitioner must complete, sign and date the claim form (the hospital/clinic will normally not provide this). Do not sign an empty, incomplete or incorrect claim form! If the doctor does not wish to complete the claim form please remind them that, if they do not do so, you will not be able to make a claim.
5. You will need to pay the clinic or hospital for your consultation & treatment, hence please ensure you collect the receipt as you will need this to reimburse eligible costs.
6. If you have been prescribed any medications, you will need to collect the prescriptions, pay for it and collect a receipt as you will need this to reimburse eligible costs.

6. Claims Reimbursement Process

What documentation is required to submit a reimbursement claim?

Before submitting any claim on a reimbursement basis to AXA, it is very important to ensure that all of the sections of the claim form have been completed and you have attached all the supporting documentation.

For reimbursement you need to ensure that...

- all fields on the claim form are complete including symptoms and treatments are complete.

If the Medical Practitioner has missed anything you will need to go back and ask him/her to properly complete his/her sections of the form.

- the claim form is stamped and signed by the treating medical practitioner
- the claim form is signed and dated by you.
- original invoices with itemized breakdown of services and proof of payment (receipts) are attached.
- physician prescriptions & referral (if any) are attached.
- investigation results (if any) are attached
- medical reports (if any) are attached*
- discharge summary (if any) is attached

- documentation relating to any medical service that you have paid for.

*Please note that we will only pay for eligible treatment cost, and not for deposits or advance invoices or registration or administration fees charged by the provider of treatment

How to submit my reimbursement claim?

You can submit your reimbursement claim online from the comfort of your home or office.

All you have to do is visit our website at www.axa-gulf.com

- Enter your personal details
- Enter treatment details
- Upload your claim documents
- You will then receive a reference number by email or SMS
- Using the reference number you can track the journey of your claim

Alternatively you may send your claim by post or visit one of our branches with all of the completed required documentation (as listed within the reimbursement claims process).

Please be aware that all documentation and claims must be submitted within 90 days of receiving the treatment for which you are claiming. Invoices sent to us after 90 days of treatment will not be eligible for settlement. Please be aware when submitting any documentation on

line you must retain all of the originals as AXA retains the right to request these on a periodic basis for further assessment.

If for any reason the claim form and supporting documentation is incomplete, this could result in the claim being returned to you for completion and may delay the processing of your claim

7. Frequently Asked Questions on Prior Approvals and Claims Processes

This section deals with some specific aspects and commonly asked questions relevant to your cover. They are not exhaustive and please contact us on any aspect of your policy that you would require further information or advice on.

Will my bill be settled directly if I have an out-patient appointment while outside the AGCC?

If you are outside the A.G.C.C. it is not possible for us to arrange to settle bills for out-patient treatment directly with the clinic or hospital. You will need to use the claims reimbursement process for all out-patient services.

Will you be able to settle my bills directly if I need to be admitted for an eligible treatment within the International network of providers?

If you need to be admitted within our international network of providers, you will need to contact us in advance, with all the necessary details of the planned treatment. Once we have the necessary information, we will be able to contact the respective provider in order to facilitate direct billing settlement accordingly.

In what currency will the claim be settled?

Unless agreed otherwise with us in writing, claim costs incurred in any currency other than what your plan has been set-up in, will be converted using the HSBC daily published exchange rate for all currencies except US Dollar. For US Dollar the fixed rate of 3.67 will be used when we assess the claim.

If we agree, in writing, in advance to reimburse benefits to a member in a currency other than what is outlined in your benefits table, 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.

What are Reasonable & Customary Charges?

Reasonable and Customary payments/charges apply when you may have used a provider outside of your designated network. This is calculated based on one of the following:

- The average negotiated cost of the treatment within the network applicable to your plan in the area in which treatment is received. Where no network exists or the treatment is not available in a network hospital we will base that calculation on the average cost of the treatment in that area or country; or
- The network in your principal country of residence if that is the calculation specifically applicable to your plan.

This will be shown as the Level of Cover in your benefits table. Your benefits table shows the designated provider network applicable to your plan.

Your benefits table shows the level of cover and the designated provider network for your plan.

Please be aware that whilst we ensure that the reasonable and customary payment is fair and reflective of the level of cover you have, choosing a

provider outside of our network can result in you contributing towards the cost of your treatment. We therefore encourage you to use your designated provider network to avoid any potential shortfalls in treatment costs.

By when do I need to send my claims documents to AXA?

You can upload your claim forms and all the supporting documentation via our website www.axa-gulf.com. Once you have uploaded the information you will receive a unique reference number which will enable you to track your claim on line.

Alternatively you can send by post all of the completed documentation (as listed within the reimbursement claims process) as soon as possible.

Please be aware that all documentation and claims must be submitted within 90 days of receiving the treatment for which you are claiming. Invoices sent to us after 90 days of treatment will not be eligible for settlement. Please be aware when submitting any documentation on line you must retain all of the originals as AXA retains the right to request these on a periodic basis for further assessment.

When will I receive settlement of the claim?

Fully documented claims are normally settled within 15 working days. Please be aware it is important that you provide all of the relevant information as listed in the reimbursement claims process to ensure there is no delay in your claims settlement.

AXA will use its best endeavors to settle all eligible reimbursement claims within 15 working days following receipt of completed documents by AXA Insurance.

What is taken as the date of receipt of complete claim documents by AXA Insurance?

The date of receipt (by AXA) of all complete documents required to substantiate, assess and validate the claim will be treated as the first date of receipt of the claim for administration purpose. It is therefore in the member's interest to ensure that all requirements are fully met to minimize any delay.

What if an illness or injury is not covered by the policy or I have exceeded the policy limits?

If the illness or injury is not covered by the policy or if the member has reached the policy limits for the benefit the member will be required to pay any shortfall to the provider. We reserve the right to recover any such sum not thus paid, being due for ineligible treatment, from the member or the company.

Can AXA ask for another Medical Opinion?

AXA reserves the right to ask for further information from your treating practitioner inclusive (but not limited to) medical reports, laboratory tests and results and radiology results. This may be needed to better assess your claim and provide the correct settlement. On occasion AXA may request a second medical opinion and this will only happen rarely. In both of these cases

AXA will not settle any claim until the full results have been received and properly assessed.

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

Where AXA Insurance is required to obtain further medical reports to clarify aspects of treatment it reserves the right to withhold payment of any claim until all such reports are received and properly evaluated.

8. Glossary

Medicine and Insurance seems to have a language all of their own. Here are some commonly used terms that we use in this standard member guide and in your Company Agreement with which you may not be familiar with. The complete list of definitions is provided in the Agreement/Policy Contract, which is held with your HR department. These definitions apply to the benefits included in our range of Healthcare Plans.

Please refer to the Benefits Table to understand the benefits that apply. If any unique benefits apply to the plan(s), those definitions will also appear in the Benefits Table.

1. **Area of cover:** Area of coverage where an insured member is allowed to avail medical treatment under the terms of the Policy.
2. **Accident:** A sudden, unforeseen, unexpected or unintended event causing a physical injury which is identifiable and is documented by the Police or Physician and is not a result of sickness, disease or gradual physical or mental process. Injury arising from accident is called accidental injury
3. **Alternative and complementary treatment:** Means therapeutic and diagnostic services that exist outside the institutions where conventional allopathic medicine is provided. Alternative/complementary health services and treatment shall be limited to only Chiropractic, Osteopathy,

Homeopathy, Acupuncture, Chinese herbal medicine and Ayurvedic treatment.

This form of treatment must be pre-approved by us in writing for Network only and be given by a qualified practitioner and must be recognized and licensed by respective authority in a country where treatment is taken. A maximum of five sessions shall be authorized in each authorization.

4. **Accidental damage to teeth:** Emergency medical treatment necessary to restore or replace sound natural teeth lost or damaged in an accident and for which medical treatment is provided within 7 days following the accident.

Please note: there is no cover for treatment required as a result of the consumption of food or drink or any foreign bodies contained in such food or drink.

Please also note: this benefit does not cover routine dental care.

5. **Ambulance:** A licensed vehicle designed for transportation of sick or injured people to/ from or between places for emergency treatment.
6. **Benefits table:** The table applicable to your plan showing the maximum benefits we will pay for each member and the area of cover within which the member may choose to receive treatment.

Please note: benefit values are reduced each time you claim only by the net amount (Invoice value less any deductible, excess, co-insurance or ineligible treatment) we have actually paid. In applying deductibles and co-insurance (the percentage of eligible benefit payable by the member) we will subtract the deductible first and then apply the co-insurance to the balance of eligible benefit remaining.

If you incur costs in excess of the limits you will have to pay the difference.

- 7. Companion accommodation:** Accommodation of a person accompanying an insured member undergoing in-patient treatment. This will be in the same room and only in cases of medical necessity at the recommendation of the treating doctor.
- 8. Co-payment/co-insurance:** A co-payment is a cost-sharing arrangement under a health insurance policy that provides that the insured will bear a specified percentage of the admissible costs.
- 9. Congenital/birth defects wording:** 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.
- 10. Daily Room and Board:** Daily Room and Board charges for a standard private room with a single bed and

single fully accessible bathroom. Please note: It does not cover deluxe, VIP, and/or suite rooms.

- 11. Deductible:** A fixed amount of money stated in table of benefits or the health insurance card which insured member is required to pay to providers in direct billing when receiving health services under table of benefits before insurance company start paying. Deductible amount is deducted from total payable claims in case of reimbursement. Deductible is applied before any co-insurance.
- 12. Dental benefit:** This benefit provides for dental consultation, extraction, composite and amalgam fillings, root canal treatment, scaling, bridgework, crowns and the treatment of gum disease. A co-insurance charge may apply as per your Benefits table. This amount will be payable by the member. No deductible other than the co-insurance applies to this benefit.
- 13. Elective Treatment:** Planned treatment which is medically necessary, but which is not required as an emergency.
- 14. Emergency:** A sudden sickness or injury whose acute symptoms raised a legitimate concern including but not limited to severe pain are of such severity that absence of immediate treatment at medical facility is medically expected to constitute a threat to:
 - i. Life; and/or

- ii. Health; and/or
- iii. Body function; and/or
- iv. Organ of the patient

This benefit does not provide cover for treatment for any condition if you have travelled outside your area of cover to get treatment (whether or not that was the only reason) or for any treatment which was, or may have reasonably been known about, before travel commenced. Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth outside your area-of-cover.

15. External prosthesis or appliances:

Medical equipment used externally from the human body which:

- a. can withstand repeated use;
- b. is not designed to be disposable;
- c. is used to serve a medical purpose; and
- d. is used outside of the Hospital.

External prosthesis or appliances that will be covered (on reimbursement basis) are: Hearing aids (Non Medical Emergency cases), speaking aids (electronic larynx) crutches and wheelchairs, orthopedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopedic arch support only if prescribed by a treating physician.

16. Health screen: Examinations, tests, consultations or other medical services that are conducted for preventative or screening reasons and which are not related to any symptom or disease is covered under Health screening. Any eligible consultation, diagnostic procedures and/or assessment costs not directly related to the treatment of a medical condition will be taken from this benefit. Note: Pre-approval is required

17. Hormone Replacement Therapy:

Hormone Replacement Therapy is covered ONLY when it is medically indicated (rather than for the relief of physiological symptoms). 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 eighteen months from the date of the first consultation.

18. Infertility treatment: The treatment for the inability to bear children, either due to the inability to become pregnant or the inability to carry a pregnancy to a live birth through the reproductive age or following either a previous pregnancy or a previous ability carry a pregnancy to a live birth.

19. International Emergency Medical Assistance:

Emergency evacuation is covered in full when you are away from the home country, and may apply if appropriate emergency treatment is not available in the country of residence. Evacuation,

when medically necessary, will always be to the nearest place where appropriate treatment can be given. A member evacuated in an emergency will subsequently be returned to their principal country of residence or Home Country. However, insured members are not entitled to be repatriated to their Home Country when admitted to a place in their country of residence.

If an Insured member passes away while abroad from their home country AXA Insurance will arrange and pay the costs of repatriation of the mortal remains to a mortuary in the Country of residence or their Home Country.

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.

20. In-patient cash benefit: A lump sum amount payable to the insured member who receives treatment as an inpatient for an eligible medical condition within area of coverage, absolutely free of charge. No other benefit will be payable in respect of the period for which the cash benefit has been paid.

21. In-patient Rehabilitation: In-patient Rehabilitation is covered ONLY when:

- i. It is an integral part of treatment; and

- ii. It is carried out by a medical practitioner specializing in rehabilitation; and
- iii. It is carried out in a rehabilitation hospital or unit which is recognized by us; and
- iv. The costs have been agreed, in writing, by us before the rehabilitation begins.
- v. We will pay for in-patient rehabilitation up to a maximum of 28 days, except in cases such as in severe central nervous system damage caused by external trauma

22. Medically Necessary: Health care services and supplies, which are determined by the Insurer to be Medically Appropriate, and

- a. Necessary to meet the basic health needs of the Eligible Person; and
- b. Rendered in the most Medically Appropriate manner and type of setting appropriate for the delivery of the Health Service, taking into account both cost and quality of care; and
- c. Consistent in type, frequency and duration of treatment with scientifically based guidelines of medical research or health care coverage organizations, or governmental agencies that are accepted by the Insurer; and
- d. Consistent with the diagnosis of the condition; and

- e. Required for reasons other than the convenience of the Eligible Person or his or her Physician; and
- f. Demonstrated through prevailing pre-reviewed medical literature to be either:
 - i. Safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed; or
 - ii. Safe with promising efficiency;
 - iii. For treating a life threatening Sickness or condition
 - iv. In a clinically controlled research setting

The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a particular Injury, Sickness or Mental Illness, does not mean that it is a Medically Necessary Covered Health Service, as defined in this Policy. The definition of Medically Necessary used in this Policy relates only to Coverage and differs from the way in which a Physician engaged in the practice of medicine may define Medically Necessary.

- 23. Medical practitioner:** A person who is registered and licensed to practice medicine by the relevant licensing authority where the treatment is being given.

This includes family and primary care doctors who diagnose, treat and prevent illness, disease, injury, and other physical and mental impairments.

This also includes practitioners who can diagnose, treat and prevent illness, disease, injury and other physical and mental impairments using specialized testing, diagnostic, medical, surgical, physical and psychiatric techniques, through application of the principles and procedures of modern medicine. They plan, supervise and evaluate the implementation of care and treatment plans by other health care providers; and specialize in certain disease categories, types of patient or methods of treatment

- 24. New Born Cover:** The Policy which covers a pregnant female is extended to provide the same benefits for a new born child of that female for a period of 30 days from date of birth; or until enrolment of the child as a dependent of the Insured Member within 30 days from birth.

For HAAD compliant product, cost of the newborn treatment is covered up to one month under mother's card as per mother's policy terms and conditions.

For DHA compliant product, new born is covered under mother's card for for 30 days from birth. New born coverage is limited to BCG, Hepatitis B and neo-natal screening tests (Phenylketonuria

(PKU), Congenital Hypothyroidism, sickle cell screening, congenital adrenal hyperplasia).

25. Network: A group of Medical Providers contracted by the Insurer or TPA for the purpose of providing Insured Members with access to their services on a direct billing basis in conformity with the terms of this Policy. Listings of Network Providers are subject to change without notice.

26. Non- Network: Medical Service Providers that are not part of the Network or, although a part of the Network, are providers that are not included within the network for a particular group, category or policy. Where the insured member does not present the Health Insurance Card to a network Provider, it will be treated as non-Network.

27. Optical Care benefit: This benefit shall cover routine optical services carried out by a qualified and registered ophthalmologist or optometrist; and costs of prescribed spectacles/corrective lenses for refractive errors.

Optical benefits shall be subject to co-insurance if applicable on all Eligible charges and will be payable by members to provider before availing benefits. No deductible other than the co-insurance applies to this benefit and sub-limit shall be inclusive of coinsurance.

Please note: the provision of tinted/reactive lenses, sunglasses, non-

corrective contact lenses, laser eye surgery or similar procedures are not covered by this benefit.

28. Organ Transplant: The replacement of vital organs (including bone marrow) as a consequence of an underlying Medical Condition, in respect of the insured person as a recipient (and not as a donor); and the organ donor at the time of transplant surgery only. We do not cover the cost of collecting the donor for the transplant surgery.

Any costs relating to acquisition, storage, administration, and/or any expenses associated with the organ will be excluded; even if such transplants are allowed by the terms of this plan. Certain transplants will not be covered based on general limitations (i.e. experimental procedures).

29. Outside area-of-cover: This is to cover emergency treatment, or treatment of a medical condition which arises suddenly whilst outside the member's area of cover. This benefit does not provide cover for treatment for any condition if you have travelled outside your area of cover to get treatment (whether or not that was the only reason) or for any treatment which was, or may have reasonably been known about, before travel commenced. Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth.

30. Parent accommodation: We will pay parent accommodation when

the child member is under 18 years old and treatment is received within your area of cover. This will be paid from the child's benefit. An extra charge for room/bed in same premises while accompanying the child shall be covered under Policy.

- 31. Physiotherapy:** Physiotherapy service may include physical-medical therapies (e.g. inhalation, physiotherapy and physical exercise, hydrotherapy and medicinal baths, cryo- and thermotherapy, electrotherapy or light therapy). Treatment must be by a Physiotherapist, who is a registered as a Medical Practitioner and licensed to practice in the country in which treatment is being given. Prior to the commencement of treatment, a referral must be issued by treating Physician specifying the diagnosis, nature and number of sessions, and must be authorized by us.

A maximum of five sessions shall be authorized in each authorization and any subsequent request for approval will be accepted by registered/treating Physiotherapist as well.

- 32. Pregnancy and Childbirth (Delivery):** The Maternity Benefit is applicable to expenses incurred for room, board and general nursing care, special hospital services and ordinary nursing care of the baby while the mother is confined in the hospital, and for charges made by the physician, or registered midwife.

Maternity benefits also include antenatal and postnatal medical expenses, including consultations, laboratory, radiology, medications, and any other covered medical expense related to the pregnancy or delivery, subject to the benefit limit mentioned in the table of benefits. Where any condition develops which becomes life threatening, the medically necessary expenses will be covered up to the annual aggregate limit. Maternity shall include Pre and post natal care, childbirth (normal delivery or caesarian section), miscarriage or legal abortion, including any and all complications arising there from. This benefit is only available for eligible married female per policy year.

- 33. Pre- and post-natal complications:** Any of the situations listed in the ICD - 10, or any subsequent version, that may occur during childbirth and/or any situation deemed by the attending clinician to require additional care or intervention, beyond that which would be required for normal course of pregnancy.

Complication of maternity affects health and life of mother and includes complication during prenatal, labor, delivery and post partum.

- 34. Prescribed drugs:** Pharmaceuticals which can only be obtained through a prescription provided by a licensed physician and which are

approved by the local regulatory authorities. Over-the-counter drugs will be excluded.

- 35. Psychiatric treatment:** This is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.

This benefit is subject to our prior written approval. The limit shown applies to in-patient, daycare and out-patient treatment in aggregate. Any deductible applies in addition to the co-insurance for all out-patient treatment under this benefit.

- 36. Preventive medical services:** Medical screening or immunization for disease prevention and health maintenance.

- 37. Reasonable and customary:** We calculate what is 'reasonable and customary' based on one of:

- i. The average negotiated cost of the treatment within the network applicable to your plan in the area in which treatment is received. Where no network exists or the treatment is not available in a network hospital we will base that calculation on the average cost of the treatment in that area or country; or
- ii. The network in your principal country of residence if that

is the calculation specifically applicable to your plan.

- 38. Reconstructive Surgery:** We will pay for reconstructive surgery ONLY 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 the original 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.

- 39. Treatment:** A medically necessary surgical or medical procedure carried out by a medical practitioner. This includes:

- i. **Diagnostic procedures:** consultations and investigations needed to establish a diagnosis.
- ii. **In-patient treatment:** Medical treatment that is provided in a hospital or other facility, and requires at least one overnight stay or more than 8 hours continuous care delivery inside a hospital and where the patient is registered as an admission.

- iii. **Daycare treatment:** treatment at a hospital, daycare unit or out-patient clinic where the member is admitted to a hospital bed, but does not require an overnight stay.
 - iv. **Out-patient treatment:** Medical care or treatment that does not require an overnight stay or that requires less than 8 hours continuous care in a hospital or medical facility. Can include Physician consultation, prescribed drugs, diagnostic tests and treatments, procedures which do not medically necessitate admission to a hospital before, during and/or after the procedure.
- 40. Vaccinations & Immunizations:** Shall be deemed to refer to the recognized and essential vaccinations and immunizations as mandated by the local regulatory authorities.
- 41. Vitamins:** Covered only when medically necessary & prescribed by a Medical Practitioner for a severe deficiency
- 42. Visit:** Each separate occasion that the member meets with a medical practitioner and receives a consultation and/or treatment for a medical condition.
- 43. Work Related Injuries:** Any accident/injury sustained by the worker during the performance or as a result of his work. This will also include any accident/injury sustained by the worker on his way to or back from his work shall be deemed an employment injury provided that the trip to or from the place of work is made directly, without delay, default or diversion from the normal route.

9. Exclusions and Limitations

WHAT WE DO NOT PAY FOR (POLICY EXCLUSIONS AND LIMITATIONS):

ALTHOUGH WE COVER MOST ILLNESSES, EXPENSES INCURRED FOR THE FOLLOWING TREATMENTS, MEDICAL CONDITIONS AND PROCEDURES ARE NOT COVERED UNDER THE POLICY UNLESS CONFIRMED OTHERWISE IN THE BENEFITS TABLE OR BY WAY OF A POLICY ENDORSEMENT.

1. HEALTH SERVICES, WHICH ARE NOT MEDICALLY NECESSARY.
2. ALL EXPENSES RELATING TO DENTAL TREATMENT, DENTAL PROSTHESES AND ORTHODONTICS
3. CUSTODIAL CARE; DOMICILIARY CARE; PRIVATE NURSING CARE; SPECIAL NURSING IN HOSPITAL, CARE OF THE SICK OF TRAVELLING. CUSTODIAL CARE MEANS:
 - i. NON-MEDICAL TREATMENT SERVICES, SUCH AS ASSISTANCE IN ACTIVITIES OF DAILY LIVING, OR
 - ii. HEALTH-RELATED SERVICES WHICH DO NOT SEEK TO IMPROVE OR WHICH DO NOT RESULT IN A CHANGE IN THE MEDICAL CONDITION OF THE PATIENT
4. SERVICES WHICH DO NOT REQUIRE CONTINUOUS ADMINISTRATION BY SPECIALIZED MEDICAL PERSONNEL).
5. PERSONAL COMFORT AND CONVENIENCE ITEMS (TELEVISION, BARBER OR BEAUTY SERVICE, GUEST SERVICE AND SIMILAR INCIDENTAL SERVICES AND SUPPLIES).
6. ALL COSMETIC HEALTHCARE SERVICES AND SERVICES ASSOCIATED WITH REPLACEMENT OF AN EXISTING BREAST IMPLANT ARE NOT COVERED. COSMETIC OPERATIONS WHICH ARE RELATED TO AN INJURY, SICKNESS OR CONGENITAL ANOMALY WHEN THE PRIMARY PURPOSE IS TO IMPROVE PHYSIOLOGICAL (NOT COSMETIC) FUNCTIONING OF THE INVOLVED PART OF THE BODY AND BREAST RECONSTRUCTION FOLLOWING A MASTECTOMY FOR CANCER ARE COVERED, PROVIDED THAT IT IS DONE AT A MEDICALLY APPROPRIATE STAGE AFTER THE ACCIDENT OR SURGERY.
7. HEALTH SERVICES AND ASSOCIATED EXPENSES FOR THE SURGICAL AND NON-SURGICAL TREATMENT FOR OBESITY (INCLUDING MORBID OBESITY), AND ANY OTHER WEIGHT CONTROL PROGRAMS, SERVICES, OR SUPPLIES.
8. TREATMENT WHICH HAS NOT BEEN ESTABLISHED AS BEING EFFECTIVE OR WHICH IS EXPERIMENTAL, MEDICALLY NON-APPROVED EXPERIMENTS AND INVESTIGATIONS AND PHARMACOLOGICAL WEIGHT REDUCTION REGIMENS. HOWEVER WE WILL PAY IF, BEFORE THE TREATMENT BEGINS, IT IS ESTABLISHED THAT THE

TREATMENT IS RECOGNIZED AS APPROPRIATE BY AN AUTHORITATIVE MEDICAL BODY AND WE HAVE AGREED, IN WRITING, WITH THE MEDICAL PRACTITIONER WHAT THE FEES WILL BE.

9. HEALTHCARE SERVICES AND ASSOCIATED EXPENSES FOR THE TREATMENT OF ALOPECIA, BALDNESS, HAIR FALLING, DANDRUFF OR WIGS.
10. HEALTH SERVICES AND SUPPLIES FOR SMOKING CESSATION PROGRAMS AND THE TREATMENT OF NICOTINE ADDICTION.
11. TREATMENT AND SERVICES FOR SEX TRANSFORMATION, STERILIZATION OR INTENDED TO CORRECT A STATE OF STERILITY OR INFERTILITY OR SEXUAL DYSFUNCTION. STERILIZATION IS ALLOWED ONLY IF MEDICALLY INDICATED AND IF ALLOWED UNDER THE LAW.
12. TREATMENT AND SERVICES FOR CONTRACEPTION.
13. THE COSTS OF PROVIDING OR FITTING ANY EXTERNAL PROSTHESIS OR APPLIANCE.
14. TREATMENTS AND SERVICES ARISING AS A RESULT OF HAZARDOUS SPORTS ACTIVITIES, INCLUDING BUT NOT LIMITED TO, ANY FORM OF AERIAL FLIGHT, ANY KIND OF POWER-VEHICLE RACE, WATER SPORTS, HORSE RIDING ACTIVITIES, MOUNTAINEERING ACTIVITIES, VIOLENT SPORTS SUCH AS JUDO, BOXING, AND

WRESTLING, BUNGEE JUMPING AND ANY PROFESSIONAL SPORTS ACTIVITIES.

15. 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 EIGHTEEN MONTHS FROM THE DATE OF THE FIRST CONSULTATION.
16. COSTS ASSOCIATED WITH HEARING TESTS, VISION CORRECTIONS, PROSTHETIC DEVICES OR HEARING AND VISION AIDS
17. 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, OR 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, MILITARY OPERATIONS, ACTS OF TERROR, OR ANY EVENT SIMILAR 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

18. INJURIES RESULTING FROM NATURAL DISASTERS, INCLUDING BUT NOT LIMITED TO: EARTHQUAKES, TORNADOS AND ANY OTHER TYPE OF NATURAL DISASTER.
19. INJURIES RESULTING FROM CRIMINAL ACTS OR RESISTING AUTHORITY BY THE INSURED PERSON.
20. MENTAL HEALTH DISEASES, IN-PATIENT AND OUT-PATIENT TREATMENTS, UNLESS THE CONDITION IS A TRANSIENT MENTAL DISORDER OR AN ACUTE REACTION TO STRESS.
21. OUTPATIENT MEDICAL 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.
22. ALLERGY TESTING AND DESENSITIZATION (EXCEPT TESTING FOR ALLERGY TOWARDS MEDICATION AND SUPPLIES USED IN TREATMENT) ANY PHYSICAL, PSYCHIATRIC, OR PSYCHOLOGICAL EXAMINATIONS OR INVESTIGATIONS DURING THESE EXAMINATIONS.
- PREVENTIVE SERVICES, INCLUDING VACCINATIONS, IMMUNIZATIONS, WILL BE COVERED AS PER DHA PROTOCOLS.
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 INPATIENT TREATMENT.
25. HEALTHCARE SERVICES FOR ADJUSTMENT OF SPINAL SUBLUXATION, DIAGNOSIS AND TREATMENT BY MANIPULATION OF THE SKELETAL STRUCTURE, BY ANY MEANS, EXCEPT TREATMENT OF FRACTURES AND DISLOCATIONS OF THE EXTREMITIES.
26. HEALTHCARE SERVICES AND TREATMENTS) BY ACUPUNCTURE; ACUPRESSURE, HYPNOTISM, ROLFING, MASSAGE THERAPY, AROMATHERAPY, HOMEOPATHIC TREATMENTS, AND ALL FORMS OF TREATMENT BY ALTERNATIVE MEDICINE UNLESS OTHERWISE SPECIFIED IN TOB.
27. ALL HEALTHCARE SERVICES & TREATMENTS FOR IN-VITRO FERTILIZATION (IVF), EMBRYO

TRANSFER, OVUM AND SPERM
TRANSFER.

28. ELECTIVE DIAGNOSTIC SERVICES
AND MEDICAL TREATMENT FOR
CORRECTION OF VISION.

29. NASAL SEPTUM DEVIATION AND
NASAL CONCHA RESECTION
UNLESS NON COSMETIC
MEDICALLY NECESSARY.

30. HEALTHCARE SERVICES FOR
PATIENTS SUFFERING FROM (AND
RELATED TO THE DIAGNOSIS AND
TREATMENT OF) HIV - AIDS AND
ITS COMPLICATIONS. PLEASE
NOTE: TREATMENT OF SEXUALLY
TRANSMITTED DISEASES
RESULTING FROM HIV-AIDS IS
EXCLUDED.

31. ANY CHARGES FOR TREATMENT
RELATED TO BIRTH DEFECTS,
CONGENITAL DISEASES AND
DEFORMITIES

FOR HAAD COMPLIANT COVER IN
ABU DHABI: THIS EXCLUSION TO
BE READ AS:

BIRTH DEFECTS, CONGENITAL
DISEASES FOR NEWBORN &/
OR DEFORMITIES UNLESS LIFE-
THREATENING.

32. ALL CASES RESULTING FROM THE
USE OF ALCOHOL, DRUGS AND
HALLUCINATORY SUBSTANCES.

33. HEALTHCARE SERVICES
FOR SENILE DEMENTIA AND
ALZHEIMER'S DISEASE.

34. AIR OR TERRESTRIAL MEDICAL
EVACUATION AND UNAUTHORIZED

TRANSPORTATION SERVICES
UNLESS APPROVED BY AXA.

35. CIRCUMCISION HEALTHCARE
SERVICES.

36. ALL CASES RELATED TO MATERNITY
IN RESPECT OF UNMARRIED
FEMALES.

37. INPATIENT TREATMENT RECEIVED
WITHOUT PRIOR APPROVAL FROM
THE INSURANCE COMPANY
INCLUDING CASES OF MEDICAL
EMERGENCY WHICH WERE NOT
NOTIFIED WITHIN 24 HOURS FROM
THE DATE OF ADMISSION.

38. ANY INPATIENT TREATMENT,
TESTS AND OTHER PROCEDURES,
WHICH CAN BE CARRIED OUT
ON OUTPATIENT BASIS WITHOUT
JEOPARDIZING THE INSURED
PERSON'S HEALTH.

39. ANY INVESTIGATION OR HEALTH
SERVICES CONDUCTED FOR
NON MEDICAL PURPOSE
SUCH AS TESTS RELATED FOR
EMPLOYMENT, TRAVEL, LICENSING
OR INSURANCE PURPOSES.

40. ANY TEST, OR TREATMENT, OR
PHARMACEUTICAL WHICH IS
NOT CONSIDERED AS SPECIFIC
TREATMENT FOR A PARTICULAR
DISEASE AND/OR NOT
PRESCRIBED BY THE TREATING
MEDICAL PRACTITIONER.

41. 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, SOAPS, TOOTH-PASTE, CONTRACEPTIVE, 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.

42. MORE THAN ONE CONSULTATION OR FOLLOW UP WITH A MEDICAL SPECIALIST (FOR THE SAME MEDICAL CONDITION) IN A SINGLE DAY UNLESS REFERRED BY THE TREATING MEDICAL PRACTITIONER.
43. TREATMENT WHICH ARISES FROM OR IS DIRECTLY OR INDIRECTLY CAUSED BY A DELIBERATELY SELF-INFLICTED INJURY OR AN ATTEMPTED SUICIDE.
44. ALL HEALTHCARE SERVICES FOR INTERNATIONALLY AND LOCALLY RECOGNIZED EPIDEMICS.
45. DIAGNOSIS AND TREATMENT SERVICES FOR COMPLICATIONS ARISING OUT OF ANY OF THE LISTED EXCLUSIONS.
46. TREATMENT DIRECTED TOWARDS DEVELOPMENTAL DELAY IN CHILDREN WHETHER PHYSICAL OR PSYCHOLOGICAL OR LEARNING DIFFICULTIES OR ANY OTHER

EDUCATIONAL PROGRAM FOR SPECIAL NEEDS.

47. HEALTH SERVICES THAT ARE NOT PERFORMED BY AUTHORIZED HEALTH SERVICE PROVIDERS.
48. ANY COSTS RELATING TO ACQUISITION, STORAGE, ADMINISTRATION, AND/OR ANY EXPENSES ASSOCIATED WITH THE ORGAN WILL BE EXCLUDED; EVEN IF SUCH TRANSPLANTS ARE ALLOWED BY THE TERMS OF THIS PLAN
49. WORK-RELATED INJURIES AND ILLNESS.
50. EXPENSES OF TRANSPORTING THE INSURED BY TRANSPORT MEANS OTHER THAN LOCAL LICENSED AMBULANCES.
51. ANY EXPENSES RELATED TO ASSISTED CONCEPTION AND COMPLICATION WHICH IS DIRECTLY RESULT OF ASSISTED PREGNANCY.

PLEASE NOTE FOR CLARITY: ANY DELIVERY AS A RESULT OF ASSISTED PREGNANCY IS COVERED IF PREGNANCY IS COVERED UNDER YOUR TOB.

MATERNITY IS A COMPULSORY BENEFIT IN EMIRATES OF ABU DHABI AND DUBAI. FOR OTHER REGIONS OR COUNTRIES, ANY EXPENSES RELATED TO MATERNITY SHALL BE IN COVERED IF BENEFITS ARE INCLUDED IN YOUR TOB AND SUBJECT TO WAITING PERIOD OR ANY CONDITIONS APPLICABLE"

- 52. TERMINATION OF PREGNANCY OR ANY CONSEQUENCES OF IT UNLESS MEDICALLY NECESSARY
- 53. 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.
- 54. ANY EXPENSES RELATED TO IMMUNOMODULATORS AND IMMUNOTHERAPY (NOT APPLICABLE FOR HAAD COMPLIANT PLANS)
- 55. ANY EXPENSES RELATED TO TREATMENT OF SLEEP RELATED DISORDERS (NOT APPLICABLE FOR HAAD COMPLIANT PLANS)

10. Contact Us

Our Customer Service Team

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, in the first instance to your HR Department. Alternatively you may contact AXA Insurance.

It is the role of our Customer Service Team to assist you, wherever possible, within the terms and limits of your AXA Insurance Plan. Our Customer Service Team and Medical Board are available 24 hours a day, 7 days a week, and 365 days a year.

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 identify you as an eligible member and assist you accordingly.

Where do I send my documents?

For UAE

AXA Insurance
Building 7
Dubai Outsource Zone Medical
Department
P.O.BOX 32505
Dubai - United Arab Emirates

For Oman

AXA Insurance Gulf B.S.C (c)
Safeway Buiding
Ground floor, Unit 1 and 2, Opp
Assarain complex Dohat al Adab Street,
Al khuwair
Sultanate of Oman

For Qatar

AXA Insurance Medical Department
Qatar Financial Centre,
6th Floor, Office 604
P.O.BOX 15319
Doha - State of Qatar

For KSA

AXA Insurance Medical Department
P.O.BOX 21044
11475 Riyadh
Kingdom of Saudi Arabia

For Bahrain

AXA Insurance Medical Department
P.O.BOX 45
Manama - Kingdom of Bahrain

Your Feedback only helps us!

Customer service is one of the most important factors that determine satisfaction level with a policy. With AXA Insurance's strong presence and reputation around the world, you can feel safe knowing that you will have someone local to support you with your medical insurance, network, and queries, no matter where you are.

We are continually striving to improve further and know about your experiences as an AXA Insurance member. We are always pleased to hear about your positive feedback. However, we would be very interested to know of any concerns that you may have on any aspect of our service.

If you have any comments or feedback, you can visit our website www.axa-gulf.com; or call the AXA Customer Service Team on any of the numbers at the back of your membership card 24 hours a day, 365 days a year.

AXA Agent

- car insurance
- health insurance
- home insurance
- travel insurance
- yacht insurance
- relocation insurance
- golf insurance
- motorcycle insurance
- personal accident insurance

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