Clauses

1. Definitions
2. Policy
3. Benefits and Coverage
4. Exclusions
5. Eligibility and Enrolment
6. Endorsements
7. Commencement and Duration of Coverage
8. Payment of Premiums
9. Payment of Benefits
10. Insurer Obligations
11. Policyholder Obligations
12. Modifications
13. Breach
14. Policy Cancellation and Refunds
15. Subrogation
16. Data Privacy
17. Third Parties
18. Force Majeure
19. Severability
20. Sanctions
21. Notices
22. Governing Law and Dispute Resolution

1. Definitions

The following definitions apply throughout this **Policy** and shall be interpreted in accordance with applicable laws and insurance regulations:

Abuse: Improper use of **Treatments**, services, or provisions to obtain **Benefits** or privileges not eligible under the **Policy** or inconsistent with **Generally Accepted Medical Practice** — such as overuse of diagnostic tests or medications.

Accident: An unforeseen, sudden, and involuntary event caused by external and identifiable means, resulting in physical injury to the **Insured Person**.

Acute: Medical Condition or symptoms that arises suddenly, are severe in nature, and typically require urgent or short-term **Treatment**. Usually of limited duration and distinct from **Chronic** or long-term **Medical Conditions**.

Anti-Selection: The act of enrolling for insurance based on knowledge of an existing or expected **Medical Condition** to gain unfair advantage, including selective or delayed enrolment to avoid risk. Such practices are prohibited and may lead to denial or cancellation of **Coverage**.

Area of Cover: The countries in which insurance **Coverage** shown in the **Table of Benefits** is available.

BASMAH Charge: A mandatory annual fee per **Insured Person** with Dubai residency, required by the **DHA**, to support the BASMAH Programme, which provides access to screening for breast cancer, cervical cancer, colorectal cancer, in line with **DHA** guidelines.

Beneficiary: A person or legal entity entitled to receive **Benefits** under this **Policy**, as designated by the **Policyholder** and listed in the **Policy Schedule.**

Benefit: A **Treatment**, service or provision available under the **Policy** to the **Insured Person**.

Benefit Limit: The maximum monetary amount specified in the **Table of Benefits** for a particular **Benefit**, applicable per **Insured Person**, and representing the total payable for valid **Claims** under that **Benefit** during the **Policy Term**. Any such **Claims** will also reduce the remaining **Policy Limit**, which remains the overall maximum payable in any **Policy Term**. If no specific **Benefit Limit** is stated, the **Benefit** is **Covered** up to the **Policy Limit**, minus the value of any other valid **Claims** already approved during the **Policy Term**.

Categories / Categorisation: The grouping of **Insured Persons** based on predefined criteria—such as job title, salary band, or grade level—for the purpose of applying differentiated **Benefits,** limits, or **Premiums** under a **Group Policy**.

Certificate of Endorsement: A document forming part of the **Policy** that details the unique **Policy** Number, **Endorsement Date**, **Policy Expiry Date**, **Policyholder's** name (company name(s) as per trade licence(s) for groups), and postal address. It confirms that additional **Insured Persons** are covered under the **Policy** from the **Endorsement Date**.

Certificate of Insurance: A document forming part of the **Policy** that confirms **Coverage** and includes key details such as the **Policy Number**, **Policy Start** and **Expiry Dates**, **Policyholder's** name (as per trade licence for groups or companies), and postal address. It certifies that **Insured Persons** are **Covered** from the **Policy Start Date**.

Chronic: Medical Conditions that are persistent or otherwise long-lasting in their effects.

Cover / Coverage: The extent of the **Benefits**, services and protection provided to the **Insured Person** under the terms of the **Policy**, as outlined in the **Table of Benefits** and subject to the **Policy's** limits, **Exclusions**, and conditions.

Claim: A request for payment of eligible expenses under this **Policy**, submitted by the **Insured Person** for **Reimbursement**, or by a **Provider** for **Direct-Billing** on their behalf.

Coinsurance: The percentage of eligible costs for a specific **Benefit** that the **Insured Person** must pay. *Example: For a **Benefit Limit** of AED 6,000 with 20% coinsurance, the **Insurer** pays up to AED 6,000, and the **Insured Person** pays 20% of each eligible bill. Any incurred costs above the AED 6,000 limit must be fully paid by the **Insured Person**.*

Congenital Condition: A **Medical Condition** that exists at or before birth, whether inherited or caused by environmental factors, and whether diagnosed at birth or later.

Country of Residence: The country where the **Insured Person** lives primarily at the **Policy Start Date** and for most of the **Policy Term**. For **Insured Persons** added later, it refers to their actual or intended primary residence as of the **Endorsement Date**.

Day Patient (Day Case): Medical **Treatment** provided in a **Hospital** where the **Insured Member** is admitted and discharged after some time without an overnight stay.

Deductible: A fixed amount the **Insured Person** must pay before the **Insurer** becomes liable to pay for eligible costs for a specific **Benefit**.

Dependants: Spouse or partner, and/or unmarried children under 19 years old, or under 26 if in full-time education, as of the **Policy Start Date**.

Developmental Disorders: A group of conditions affecting physical, cognitive, behavioural, emotional, adaptive or social development, including but not limited to autism spectrum disorders, attention deficit hyperactivity disorder (ADHD), intellectual disabilities and specific learning disorders.

DHA: Dubai Health Authority.

Direct-Billing: A service where the **Network Provider** charges the **Insurer** directly for **Treatments**, services, and provisions, so the **Insured Person** does not have to pay at the time of receipt upon being identified as an **Insured Person**.

DOH: Department of Health, UAE.

Emergency: A sudden, unforeseen and severe **Medical Condition** or injury that requires urgent medical assistance. **Emergency** medical **Treatment** will only be covered up to the point where the **Medical Practitioner** in charge of the **Insured Person's Treatment** advises that their **Medical Condition** has stabilised.

Enrolment List: A list that forms part of the **Policy**, detailing the names and information of all members covered from the **Policy Start Date**, as well as any subsequent lists with details of **Insured Members** added to the **Policy** thereafter.

Endorsements: Official changes to the **Policy** relating to the list or details of active **Insured Persons**, including member additions, deletions, or updates to personal information, as confirmed by the **Insurer**.

Endorsement Date:
The date on which **Coverage** for an **Endorsement** becomes effective (or in the case of a deletion ends) as confirmed by the **Insurer**.

Exclusion: Any **Medical Condition**, **Treatment**, service, provision or item that is not **Covered** under this **Policy**, whether explicitly listed or implied by the terms herein.

Fraud: Any deliberate act of deception, misrepresentation, or concealment of material facts by the **Policyholder** and/or **Insured Person**, intended to obtain or assist in obtaining **Benefits**, services, **Reimbursements**, or privileges under the **Policy** to which they are not lawfully entitled. This includes, but is not limited to, falsifying **Claims**, altering documents, providing false information during application or **Claims** processes, or colluding with **Providers** to submit inflated or fabricated charges.

Generally Accepted Medical Practice: Medical **Treatments**, procedures, or services that are widely recognised, approved, and routinely used by the medical community, based on clinical evidence and professional standards, and which are considered appropriate and effective for a given **Medical Condition** by qualified **Medical Practitioners**.

Group Policies: Insurance **Policies** issued to an organisation or employer to provide **Cover** to a defined group of eligible members—typically employees—and optionally their **Dependants**, under a single contract managed by the **Policyholder**.

Helpline: A 24/7 phone service available to **Insured Persons** for information, assistance, advice, and support related to their **Cover** or **Policy Benefits**.

HCV Charge: A mandatory annual fee per **Insured Person** with Dubai residency, required by the **DHA**, to support the HCV Programme, which provides access to **Treatment** and screening for Hepatitis C**,** in line with **DHA** guidelines.

Home Country: The country of **Nationality** to which an **Insured Person** would wish to be repatriated, as confirmed by the **Insurer** in the **Policy Schedule**.

Hospital: An establishment licenced as a medical or surgical hospital in its country of location, where patients receive care or supervision from a **Medical Practitioner** or a **Nurse**.

Individual & Family Policies: Insurance **Policies** issued to a private individual (the **Policyholder**) to provide **Cover** for themselves and/or their **Dependants**—such as a spouse or children—under a single **Policy**. The **Policyholder** may or may not be one of the **Insured Persons**.

Inpatient: Medical **Treatment** provided during a stay in a **Hospital** where the **Insured Member** is formally admitted and stays for at least one night.

Insurance / Membership Card: An E-card issued for each **Policy Term** that can be viewed in the **WellX** Mobile Application.

Insured Person/Member: An individual who is entitled to receive **Coverage** under this **Policy** and is listed by name in the **Policy Schedule** or **Certificate of Insurance**.

Insurer: Dubai National Insurance (DNI), a licenced insurance company in the United Arab Emirates that provides **Coverage** under **OpenX** health insurance plans.

Loading: An additional amount of **Premium** added to the standard **Premium** based on factors such as the **Insured Person's** age, medical history, or overall risk profile. Loadings are applied at the **Insurer's** discretion and may be reassessed, adjusted for inflation, or reviewed at **Renewal**.

Medical Application Form (MAF): A health declaration form completed by the person seeking **Insurance Cover**, for **Underwriting** purposes.

Medical Condition: Any disease, illness, injury, or psychiatric disorder affecting the physical or mental health of the **Insured Person**.

Medically Necessary: Any medical **Treatment**, service or provision that, in the opinion of a qualified **Medical Practitioner**, is appropriate and consistent with the diagnosis, and which, based on **Generally Accepted Medical Practice**, could not be omitted without negatively affecting the **Insured Person's** condition or the quality of essential medical care.

Medigo: The designated **Third-Party Administrator (TPA)** responsible for managing cashless payments for hospitalisation-related medical **Claims** incurred outside the UAE, where specified in the **Table of Benefits**.

Medical Practitioner: A doctor or specialist who is licenced or registered to practise medicine under the laws of the country or jurisdiction where the **Treatment** is provided and is practising within the scope of that licence.

NAS: The primary administrator appointed under this **Policy** to manage **Claims**, approvals, and **Network** access within the UAE, Bahrain, Kuwait, Oman and Qatar. NAS also handles all **Claims** and support for **Insured Members** outside the UAE where **Medigo** is unable to provide cashless facilitation.

Nationality: An **Insured Person's** affiliation with a specific nation, as demonstrated by a current, valid passport and recorded by the **Insurer**.

Network: The list of **Providers** and facilities contracted with the **Insurer** to provide **Treatments**, services and provisions to **Insured Persons** at negotiated rates on a **Direct-Billing** basis. The **Providers** contained in any **Network** are subject to change from time to time without notice for example due to suspension, blacklisting or network tier reallocation. Updated lists are available monthly.

Network Provider: A **Provider** in the **Network** through which **Direct-Billing** is available.

Newborn: An infant within the first 30 days of life after birth, eligible for **Newborn Cover** if the mother is insured under the **Policy**.

Newborn Cover: A **Newborn** is covered under the mother's **Policy** with the same benefits and **Coverage** as the mother for the first 30 days from birth, plus:
a) Routine neonatal physical examinations
b) Standard hearing test
c) Critical congenital heart disease screening
d) Standard neonatal lab screening (heel-prick/blood-spot tests)
e) Vaccinations: BCG, Hepatitis B, and Vitamin K
f) **Treatment** of life-threatening conditions or congenital defects
g) Any additional services required under applicable local laws and regulations

If the **Newborn** remains hospitalised beyond the initial 30 days, continued **Cover** may be provided under a separate **Policy** issued in the **Newborn**'s name, if enrolled accordingly.

Nurse: A healthcare professional who is qualified, registered, and licenced to provide nursing care in the country where services are delivered, and who operates within the scope of their licence.

OpenX: The health insurance plan name.

Outpatient: Medical **Treatments**, consultations, procedures, or diagnostic services provided without admission to a **Hospital** meaning the **Insured Member** is not required to stay overnight.

Psychotherapy & Psychiatry: Psychotherapy & Psychiatry: Treatment of a clinically diagnosed mental disorder by a licenced psychiatrist or clinical psychologist, where the condition meets DSM-5 or ICD-10/ICD-11 diagnostic criteria and causes clinically significant distress or impairment in occupational, social, or daily functioning. Treatment must be prescribed and overseen by a qualified Medical Practitioner and delivered by a licenced mental health professional within their scope of registration. Excluded are Developmental Disorders and conditions arising solely from situational stressors (e.g. bereavement, relationship breakdown, academic difficulty, or acculturation), unless these have precipitated a diagnosable psychiatric disorder meeting the above criteria.

Pre-existing Condition: Any **Medical Condition** that existed or was diagnosed prior to the initial **Policy Start Date** or, for **Insured Persons** added later, prior to the date they are first added to the **Policy**, regardless of whether the **Insured Person** was aware of it.

Premium: The financial consideration payable by the **Policyholder** to the **Insurer** for providing **Coverage** under this **Policy**.

Pre-Natal: All reasonable and customary consultations and care provided by a qualified obstetrician in accordance with local laws and regulations.

Prior (Pre-) Approval: Advance authorisation from the **Insurer** or **TPA** as mentioned as required for certain **Benefits** in the **Table of Benefits**. **Claims** without **Prior Approval**, where required, may be rejected or reduced.

Policy Expiry Date: The last day of **Coverage** under this policy, as specified in the **Policy Schedule**, after which no **Benefits** will be provided unless the **Policy** is renewed.

Policy Limit: The maximum aggregate amount payable by the **Insurer** for all eligible **Benefits** provided to an **Insured Person** during the **Policy Term** as stated in the **Policy Schedule**.

Policyholder: The individual or entity that holds the insurance **Policy**, responsible for ensuring **Premium** payments and fulfilling the **Terms and Conditions** of the **Policy**. This may refer to the **Insured Person** or the person or entity managing the **Policy** on behalf of all the **Insured Persons**.

Policy Schedule: A document issued by the **Insurer** outlining specific **Coverage** details including the **Table of Benefits**, **Premiums** and the **Enrolment List/s** of **Insured Persons.**

Policy Start Date: Also known as the inception date, it is the date on which **Coverage** under this **Policy** begins, as specified in the **Certificate of Insurance**.

Policy Term: One calendar year starting from the **Policy Start Date**.

Private Room: A standard single-occupancy hospital room with en-suite facilities. Where a **Benefit** specifies Private Room, the **Insured Person** may also be accommodated in a lower category room (e.g. semi-private or ward).

Provider: A licenced individual, hospital, clinic, dentist, optician, pharmacy, or other entity approved by the **Insurer** to deliver **Covered Treatments**, services and provisions.

Reimbursement: Also known as (Pay & Claim) is a process where **Insured Persons** pay for eligible medical **Treatments**, services and/or provisions upfront and submit **Claims** to the **Insurer** for reimbursement, subject to **Policy** terms, limits, and any required documentation. Applicable when **Treatments**, services or provisions are not covered under **Direct-Billing**.

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Renewal: The continuation of the **Policy** for a further **Policy Term** beyond its **Policy Expiry Date**, subject to mutual agreement between the **Policyholder** and the **Insurer**. Renewal may involve revised terms, conditions, **Benefits** or **Premiums** which the **Insurer** will endeavour to share with the **Policyholder** not less than 30 days before the **Renewal Date**.

Renewal Date: The annual anniversary of the **Policy Start Date**, as stated on the **Certificate of Insurance**.

Roaming: An enhanced level of **Coverage** in the **Area of Cover Benefit,** with **Coinsurance** payable only on **Outpatient Treatments**, services and provisions in higher **Providers** found in the highest 1 (one) or 2 (two**) Networks,** as specified in the **Table of Benefits**.

Slash / ICP Data Fee: A mandatory annual fee per **Insured Person** with UAE residency (excluding Dubai residents), required by the **DOH**, to support the linking of health insurance the Emirates IDs.

Terminal Illness: A diagnosed illness or **Medical Condition** for which a **Medical Practitioner** has determined the **Insured Person** has a life expectancy of six

months or less, with no reasonable hope of recovery or response to further curative **Treatment.**

Table of Benefits (TOB): A table listing out the benefits, elaborations, limitations, co-payments and **Coverage** details applicable to this **Policy**.

Treatment: Any medical, surgical, or therapeutic procedure, or prescribed medication, provided solely to cure or relieve a **Medical Condition**.

Third-Party Administrator (TPA): An independent organisation appointed by the **Insurer** to manage administrative tasks such as **Claims** processing, **Provider Network** coordination, and customer service on behalf of the **Policy**. See also **NAS** and **Medigo.**

UAE Network Rates: The benchmark **Direct-Billing** rates for **Treatments** and services for the **Network** specific to an **Insured Person's Cover**, as per specific **Provider's** standard **Network** rates.

Underwriting: The process of assessing risk to determine eligibility, terms of **Cover**, and any adjustments to **Premiums**.

Usual Customary & Reasonable (UCR): The standard charge for a **Treatment**, service or provision in a specific country or region. If the cost of an eligible **Treatment**, service or provision exceeds the UCR amount, the **Insurer** may only pay up to the UCR amount.

Waiting Period: The initial period after the **Policy Start Date** during which a **Benefit** is not payable under this **Policy**, as specified in the **Policy Schedule**.

Wellxai Technologies Limited (Wellx): The wellness and wellbeing provider of the for these **OpenX** plans and accessible to **Insured Persons** through the **Wellx** Mobile Application.

2. Policy

The contract between the **Insurer** and the **Policyholder**, made up of any completed forms and any supplementary information provided by the **Policyholder**, the **Certificate(s) of Insurance, Policy Schedule, Terms & Conditions, Network(s),** any subsequent written agreements and/or **Endorsements**, **Certificates of Endorsement** and any relevant legal regulations and laws.

3. Benefits and Coverage

All **Benefits** are as stated in the **Table of Benefits** and are subject to these **Terms & Conditions**, applicable limits, **Coinsurance, Deductibles**, **Waiting Periods**, and **Exclusions**. **Benefits** will be payable only for expenses incurred during the **Policy Term**, within the **Area of Cover**, and from eligible **Providers**, unless otherwise stated. **Medically Necessary Treatments** are **Covered**, as well as any preventive, elective, or other non-**Medically Necessary** services expressly listed in the **Table of Benefits**. All payments may be limited to **Usual, Customary and Reasonable (UCR)** charges, and remain subject to any applicable regulatory requirements.

4. Exclusions

In addition to any items marked as "Not Covered" in the **Table of Benefits**, the following **Treatments**, Services, or Provisions are excluded unless expressly stated as Covered. This includes those that are, are for, or are related to the following:

1) Not **Medically Necessary**.
2) Cosmetic.
3) Preventive.
4) Custodial care.
5) Obesity and weight control.
6) Experimental or investigative.
7) Unauthorised **Providers** or **Practitioners**.
8) Hair loss and baldness.
9) Drug or substance abuse, addiction or addiction cessation.
10) Birth control and related complications.
11) Gender confirmation, sterility, infertility or sexual dysfunction.
12) Sleep related disorders.
13) Participation professionally in sports or hazardous activities.
14) Self-administered or family-provided.
15) Infertility and assisted reproduction.
16) **Developmental Disorders**.
17) Active participation in war or civil disturbance, political violence or terrorism.
18) Exposure to nuclear, chemical or biological weapons.
19) Participation in criminal, illegal or unlawful acts.
20) Complications of excluded **Treatments** and illnesses.

5. Eligibility and Enrolment

5.1 This **Policy** is available to UAE residents with valid Emirates ID and visa. For **Group Policies**, the **Policyholder** must be a registered UAE entity, and **Cover** may extend to full-time employees and their eligible **Dependants**

5.2 At the **Insurer's** discretion, **Cover** may extend to employees living outside the UAE, provided they are directly employed by and affiliated with the **Policyholder**, and the **Policyholder** is a UAE-registered entity. If UAE-resident **Dependants** are covered, then all eligible **Dependants** of employees living outside the UAE must also be covered, provided they live in the same country as the eligible employee. **Insured Persons** residing in the UAE must always remain most of the **Covered** population. All other **Policy Terms and Conditions**, including **Eligibility** requirements and **Anti-selection** provisions, will continue to apply, and **insured Persons** living outside the UAE will be subject to the same **Terms and Conditions** as those residing within the UAE.

5.3 Employees may be grouped under different **Categories** based on role or grade, with proof. If **Dependants** are **Covered**, they must be enrolled under the same **Category** as the employee. If a **Group Policy** starts with 10 or more **Insured Members** and subsequently falls below 10, or if the overall membership at the **Policy Start Date** drops by more than 30%, the **Insurer** may revise the **Policy** terms without notice. The **Policyholder** must submit accurate enrolment data and notify the **Insurer** of changes in member status.

5.4 Medical exams may be required for any person before **Cover** is approved.

5.5 All new joiners to an Individual and Family **Policy**, or to a **Policy** covering fewer than 10 lives at inception or at the last **Renewal Date**, must complete a **Medical Application Form (MAF)** and will be subject to **Underwriting**, whether they are enrolled at **initial Policy Start Date** or added later. The same applies to new joiners to any **Policy** that started or renewed with 10 or more lives but later fell below 10 lives.

5.6 All new joiners aged 66 and above, whether enrolled at initial **Policy Start Date** or added later, must complete a **Medical Application Form (MAF)** and will be subject to **Underwriting**. Those aged 70 and above must also submit a medical examination report as specified by the **Insurer**.

5.7 Individuals requiring permanent care at the start of **Cover** are not eligible.

5.8 All eligible members should be enrolled from their date of eligibility. Any late joiner to the **Policy** may be required to complete a **Medical Application Form (MAF)** and be subject to **Underwriting**, in accordance with the **Insurer's** underwriting rules

5.9 **Anti-Selection** is not permitted. This **Policy** assumes timely and complete enrolment of all eligible persons:

- **Group Policies:** All full-time employees, or employees of a similar level (if approved), must be enrolled. If **Dependants** are included, all must be enrolled unless already insured elsewhere (evidence may be required), this applies consistently across that employee **Category.**
- **Individual & Family Policies:** If one **Dependant** is **Covered**, all must be enrolled unless already insured elsewhere.

5.10 Selective or delayed enrolment may lead to restriction, denial of **Benefits**, or **cancellation.** (See Clause **13. Policy Cancellation and Refunds**).

5.11 Proof of existing suitable medical insurance is required to exclude any eligible person from this **Policy**, if requested.

5.12 **Category** changes are only allowed at **Renewal** and/or with **Insurer** approval.

6. Endorsements

6.1 Additions

6.1.1 New joiners may be added to the **Policy** becoming **Insured Persons** upon application with pro-rated (from the **Endorsement Date** to the **Policy Expiry Date) Premiums** charged.

6.1.2 New joiners will be subject to the same declaration requirements as those who joined the **Policy** at inception.

6.1.3 **Groups** must provide proof of employment from the requested **Endorsement Date**.

6.1.4 **Newborns** may be added under the mother's **Policy** if requested in writing within 30 days of birth, with their own **Cover** starting from day 31. After 30 days, they can still be added from the date of request, subject to **Underwriting** at the **Insurer's** discretion.

6.1.5 New spouses may be added from the date of marriage.

6.1.6 Newly adopted children may be added from the official date of adoption.

6.1.7 Payments must be made in line with the invoice terms.

6.2 Deletions

6.2.1 **Insured Persons** may be deleted from the **Policy** upon application with pro-rated (from the **Endorsement Date** to the **Policy Expiry Date) Premiums** refunded.

6.2.2 For **Individual & Family Policies** the value of the **Claims Covered** for the deleted **Insured Person** up to the **Endorsement Date** will be deducted from the final refund.

6.2.3 Deletions in **Group Policies** are only accepted upon termination of employment (including notice period) in line with any applicable laws and regulations (such as visa cancellation, proof of insurance, exit stamps, etc), or death.

6.3 Detail Changes

6.3.1 The **Insurer** must be promptly notified of the following changes for **Insured Persons**:

(i) **Country** (or Emirate) **of Residence**.
(ii) Marital Status.
(iii) Nationality.
(iv) Employment status.

Cover may continue with adjustments.

7. Start and Duration of Coverage

7.1 The **Policy** takes effect upon issuance of the **Certificate of Insurance** by the **Insurer**.

7.2 **Coverage** begins on the **Policy Start Date** and ends on the **Policy Expiry Date** as stated in the **Certificate of Insurance**. For **Insured Persons** added to the **Policy** after the **Policy Start Date**, **Coverage** begins on the **Endorsement Date**.

7.3 **Cover** ends on the earliest of the following:
– The **Policy Expiry Date.**
– The date the **Insured Person** dies or is removed from the **Policy.**
– The date of **Cancellation** or **Termination.**

7.4 In the event of **Cancellation** or **Termination**, the **Policyholder** must immediately inform all **Insured Persons**.

8. Payment of Premiums

8.1 All **Premiums** must be paid in full by the due date(s), as per the agreed schedule. **Payment** is deemed complete once the full amount is received in the **Insurer's** bank account.

8.2 If any payment is withheld or delayed, the **Insurer** may charge interest at 1.6% per month (calculated daily) on the overdue amount and may suspend or cancel the **Policy** and its **Cover** at any time.

8.3 If the **Policy** is suspended, eligible costs incurred with a **Network Provider** will be reimbursed once overdue payments are settled, but only up to the applicable **Network Rates**.

9. Payment of Benefits

9.1 **Claims** must be properly documented. The **Insurer** may reject any **Claim** lacking authenticity or submitted in bad faith.

9.2 **Direct-Billing Claims** will be paid directly to **Providers**, but the **Insurer** may deny payment with reasons.

9.3 If **Direct-Billing** is not used with a **Network Provider**, **Reimbursement** may be capped at the applicable **(UCR)**.

9.4 **Reimbursement** may be withheld if original invoices/receipts are not provided. If submitted to another insurer, marked copies may be accepted.

9.5 Invoices must include the treating **Medical Practitioner's** name, **Insured Person's** name and date of birth, diagnosis, and treatment details.

9.6 **Claims,** including those amended or resubmitted, may be declined.

9.7 **Reimbursements** will be in the **Country of Residence** currency; foreign **Claims** will be converted at the payment date exchange rate.

9.8 Transport **Claims** require a doctor's written confirmation of **Medical Necessity**.

9.9 **Claims** submitted more than 180 days after the invoice date are not payable.

9.10 If a **Claim** is false, misleading, or is in **Breach** the **Policy**, it may be denied. Partial payment may be considered if liability is unaffected.

9.11 The **Insurer** may recover ineligible or mistaken payments.

9.12 If a **Claim** is rejected, the Insurer is not liable unless its validity is legally established within 180 days (or as required by law) from the date of communicating the rejection.

9.13 **Reimbursement** is limited to **Usual, Customary and Reasonable (UCR)** charges.

9.14 A second opinion may be required if the medical basis of a **Claim** is disputed.

9.15 **Claims** from blacklisted **Providers** will not be paid if incurred after notice of blacklisting.

10. Insurer Obligations

The duties of the **Insurer** under this **Policy**, including providing the agreed **Coverage**, processing **Claims** in accordance with the **Policy Terms & Conditions**, paying eligible **Benefits** (either directly or through an appointed third party), and acting conscientiously and in good faith in all dealings with the **Policyholder** and **Insured Persons**.

11. Policyholder Obligations

11.1 The **Policyholder** and each **Insured Person** must comply with the following duties under this **Policy**:

i) Act honestly and in good faith in all dealings with the **Insurer**.
ii) Provide timely, accurate information and supporting documents as requested.
iii) Cooperate fully in claims investigations, including medical exams by **Insurer**-appointed **Providers** and authorise release of relevant information.
iv) Disclose any other insurance covering the same risk and submit **Claims** to those **Insurers** before seeking payment under this **Policy**.
v) Take reasonable steps to prevent further loss and follow medical advice for recovery.
vi) Provide a certified death certificate in the event of an **Insured Person's** death.
vii) Promptly notify the **Insurer** of any changes to contact or personal details relevant to the **Policy**.
viii) Ensure all **Premium** payments are made by their due dates.

11.2 The **Policyholder** is responsible for informing all **Insured Persons** of their obligations under this **Policy** and for enforcing compliance as a condition of **Coverage**. While **Insured Persons** are not direct parties to this **Policy**, failure to comply with these obligations may result in denial or delay of **Claims**.

11.3 Strict compliance with these obligations is a condition precedent to the **Insurer's** liability under this **Policy**.

12. Modifications

The **Insurer** may adjust the **Premium**, **Coverage, Benefits** or **Terms** at **Renewal** and will notify the **Policyholder** in advance. During the **Policy Period**, the **Insurer** may also make reasonable changes to comply with laws, regulations, or government directives. Any resulting **Premium** adjustments will be effective immediately, unless otherwise agreed. The **Policyholder** may not request changes during the **Policy Period,** but requests may be considered at **Renewal** at the **Insurer's** discretion.

13. Breach

If there is a **Breach** of any **Obligation** under this **Policy**, the **Insurer** reserves the right to terminate the **Policy** with immediate effect or to terminate **Coverage** for the **Insured Person** responsible for the **Breach**, including in cases of **Fraud**. For this purpose, any knowledge or misconduct of an **Insured Person** shall be deemed to be the knowledge or misconduct of the **Policyholder**.

The **Insurer** further reserves the right to amend the terms, rates, and conditions of this **Policy** if it subsequently becomes aware that material facts were not disclosed or were incorrectly stated, and that such facts materially affect the insured risk or the **Policy** as presented at quotation. Any deliberate, fraudulent, or reckless non-disclosure or misrepresentation, whether at **Policy** inception or on the addition of any member, may result in cancellation of the **Policy** or declinature of a **Claim**.

14. Policy Cancellation and Refunds

14.1 **Group Policies:**
The **Policyholder** may request cancellation at any time, unless there has been a serious **Policy Breach**. Cancellation takes effect 30 days after written notice is received by the **Insurer**.

If cancelled, a refund will be provided for the unused portion of the **Premium** (calculated on a daily pro-rata basis) after 90 days from the date the cancellation takes effect, minus either:
a) the total of all **Claims** paid and pending, or
b) 30% of the total **Premium**—
whichever is greater.
No refund applies if **Claims** exceed the remaining **Premium**.

14.2 **Individual & Family Policies:**
Cancellation takes effect from the date a written request is received by the **Insurer** or at a subsequent date if so requested**.** A pro-rated refund, minus any **Claims**, will be processed within 90 days of cancellation.

14.3 **All Policies:**
If the **Policy** is terminated due to a **Breach**—such as **Fraud** committed by the **Policyholder** or any **Insured Person**—no refund will be issued.

15. Subrogation

Where a **Claim** paid under this **Policy** is also eligible for recovery or partial recovery from a third party (such as another insurer, scheme, or benefit provider), we reserve the right to recover that amount. The **Policyholder** and any **Insured Person** must not waive any such right without the **Insurer's** consent and they must cooperate with us in facilitating such recovery, including providing relevant information or assistance where reasonably required. If such right is unduly waived, then the **Policyholder** is liable to the **Insurer** for any amount that otherwise may have been recoverable.

16. Data Privacy

16.1 The **Insurer** collects and processes personal data—including health, lifestyle, and app usage information—to provide and enhance insurance and wellbeing services. Personal data is handled in accordance with UAE data protection laws.

16.2 All data is stored securely using industry-standard safeguards. Where data is transferred outside the UAE, we ensure appropriate protection measures are in place in line with legal requirements.

16.3 Your data will only be accessed by authorised personnel or trusted third parties when necessary for service delivery, regulatory compliance, or with your explicit consent.

16.4 You have the right to access, correct, or request deletion of your personal data, and to withdraw your consent at any time. For data access or privacy concerns, please contact us through the details provided in this **Policy**.

17. Third Parties

The **Insurer** may share your personal data with trusted third parties—such as **Providers**, technology partners, and regulators—only as needed to deliver our services, comply with legal obligations, or enhance your wellbeing experience. These parties are contractually required or legally bound to protect your data and use it solely for the specified purposes.

This **Policy** is a contract between the **Insurer** and the **Policyholder**. Only the **Policyholder** and the **Insurer** have rights and obligations under this **Policy**. No third party (including **Insured Persons**) may enforce any part of this agreement, except as beneficiaries of the **Policy**.

18. Force Majeure

The **Insurer** is not liable for delays or failures caused by events outside our control—like natural disasters, war, or government actions—that prevent the provision of its obligations under this **Policy**.

19. Severability

If any part of this **Policy** is found to be invalid or unenforceable, the remaining terms will continue in full force and effect.

20. Sanctions

Notwithstanding any other provision of this **Policy**, the **Insurer** shall not be deemed to provide **Cover**, pay any **Claim**, or provide any **Benefit** to the extent that doing so would expose the **Insurer**, its **Reinsurer**, or any party acting on its behalf to any applicable sanction, prohibition, restriction, law, or regulation. The **Policyholder** and each **Insured Person** shall provide such information and supporting documents as the **Insurer** may reasonably require for compliance. The **Insurer** shall not be liable for any restriction, prohibition, delay, or non-payment to the extent required for such compliance.

21. Notices

All notices to the **Insurer** must be submitted in writing and addressed to:

Dubai National Insurance & Reinsurance Co. (PSC),
Dubai National Insurance Building,
3rd Floor, Sheikh Zayed Road,
P.O. Box 1806, Dubai, UAE

Alternatively, notices may be sent to any address later provided in writing by the **Insurer**. Notices will be sent by registered mail or courier to the **Policyholder's** last known address. Intermediaries or agents are not authorised to receive notices for the **Insurer**.

22. Governing Law and Dispute Resolution

This **Policy** is subject to the rules and regulations of the **Dubai Health Authority (DHA)**, **the Department of Health – Abu Dhabi (DOH)**, and the Central Bank of the UAE (CBUAE). Where any provision of this **Policy** conflicts with applicable insurance regulations, those regulations shall prevail.

To the extent not governed by such regulations, this **Policy** shall be construed in accordance with DIFC law. All disputes arising out of or in connection with this **Policy** shall first be referred to the applicable regulator. If unresolved, disputes shall be subject to the exclusive jurisdiction of the DIFC Courts, unless the parties agree to arbitration under the DIFC-LCIA Arbitration Rules, conducted in English and seated in the DIFC.