



Gulfcare Member Healthcare Plan

Beyond Healthcare





About this guide

This guide is designed to explain the benefits provided under the Gulfcare Plan and to give you useful information on how the Plan works.

We encourage you to read the guide carefully, together with the Table of Benefits and the Network List provided with your digital Membership Card.

There is a Useful Definitions & Abbreviations section on Page. Useful definitions are highlighted in this guide for ease of identification.

Introducing QIC & NAS

Qatar Insurance Company (QIC) is the medical insurance provider. QIC is the largest insurance company in the Middle East, with branches in the UAE, Kuwait, Oman and Qatar.

Their partner, NAS, administers the plan. This means that NAS provides the medical network and operates the Gulfcare plan on a day-to-day basis, such as managing pre-approvals, claims reimbursement, and emergency assistance.



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Your Healthcare Benefits

The Plan provides you with cover for comprehensive health care services, such as out-patient consultations and treatment, diagnostics, radiology and laboratory tests, prescription drugs, in-patient treatment and services, and licensed ambulance services to and from hospital in case of emergency.

You have received a Table of Benefits with your digital Membership Card, providing you with full details of your benefits under the Plan. Please make sure you read your Table of Benefits carefully, and also review the list of Exclusions. If you would like to check whether your treatment is covered by the Plan, simply contact the NAS Contact Center for assistance, using the contact details under the "Member Services" section on Page .

The Plan includes cover for Pre-Existing Conditions and Chronic Conditions, provided your condition would usually qualify for cover under your Table of Benefits.

Pre-Approvals

Some Elective Treatments and services require pre-approval from our insurer before they are carried out, including:

- All In-Patient Treatment and related services;
- All Day-Case Treatment and related services;
- All Out-Patient surgical procedures above AED 5,000 (USD 1,361);
- Consultations and clinical procedures above AED 5,000 (USD 1,361);
- Any other laboratory tests and diagnostics above AED 5,000 (USD 1,361);

No pre-approval is required in case of a Medical Emergency. However, the NAS Contact Center must be informed within 24 hours of hospital admission, before discharge.

Additional information on pre-approvals is included in the "How to Use Your Medical Plan" section.

To check if your treatment requires pre-approval, please contact the NAS Contact Center.

Outpatient Deductible

An out-patient Deductible applies for some membership categories under the Plan. If a Deductible applies for you, this is shown on your Table of Benefits.

The Deductible applies on out-patient consultations only. No Deductible is payable for a follow-up visit within 10 days of your original consultation.

Co-Insurance

A Co-Insurance applies on some benefits under the Plan, such as psychiatric treatment. Details are provided in your Table of Benefits.



Your Network

The Plan provides you with access to a wide range of hospitals, clinics, diagnostic centers and pharmacies within the NAS medical provider network.

We encourage you to use a Network Provider whenever possible, to take advantage of the following benefits:

- Direct-billing arrangement with NAS. This means that you pay only your applicable Deductible and Co-Insurance at the time of your appointment; all other eligible charges are invoiced directly to NAS by the Network Provider.
- No claims reimbursement forms or other documents required.
- Pre-approvals are arranged directly by the Network Provider with NAS.
- Treatment is fully-covered within the Network, subject to the limits in your Table of Benefits.

You can also search for a Network Provider by type of facility and location using the myNAS online member portal and the myNAS app. Further details on these services are provided later in this guide.

Treatment Outside Your Network

If you choose to visit an out-of-network facility, all expenses will be on a reimbursement basis only. This means you will need to pay the provider for the full costs of your treatment, then submit a Claims Reimbursement Form to NAS for reimbursement. Information on how to submit a claim is provided later in this guide.

Treatment Overseas

If you have treatment outside your employment country where there is no NAS network, all expenses will be on a reimbursement basis only, unless you obtain a Treatment Guarantee from NAS and your provider agrees to accept the guarantee. Please contact the NAS Contact Center before making any arrangements for overseas treatment.



Member Services



Your digital Membership Card

Your digital Membership Card will be issued when you are enrolled in the Plan. If your family members are also enrolled in the Plan, you will receive separate digital cards for each member. An example card is shown below.



The “Card No.” on the front of the card is your membership number; you can use this number to register for the myNAS online member portal and the myNAS app. Further details on these services are provided below.

NAS Contact Center

NAS offer a 24-hour multi-lingual Contact Center to assist you in case of emergencies and pre-approval requirements, to follow up on claims submissions, and to answer general questions about the Plan.

The contact telephone numbers are:

- UAE: 8003311 (toll-free) or +971 2 694 0707
- Kuwait: +965 2 225 0240
- Oman: +968 2 4667715
- Qatar: +974 4 4231214
- Bahrain: 80006216
- International 24 hr Assistance CEGA: +44 1243 621 074 (If calling from outside UK)
- CEGA UK : 01243 621 074 (While in UK)

The NAS Contact Center is also available by e-mail at claimscenter@nas.ae, and CCMedicalOfficers@nas.ae, both in “To” section with Medical report, supporting investigations reports and cost estimate.



myNAS Online Member Portal

NAS offers an online member portal allowing you to access a range of services at any time. You can:

- Search for a Network Provider by name, location, type of facility or services offered, and save your favorites for easy access to their information in future
- Access Table of Benefits
- Download a Claim Reimbursement Form
- Submit a claim
- Track the progress of your claims and approvals, and view your claims history
- View and update your member profile, including your mobile number and your bank account details for claims payment

Simply go to mynas.ntouch.cloud then click "Join Now" to register for the myNAS portal.

Please refer to the user manual for myNAS webportal:

myNAS Mobile App

The myNAS mobile app allows you convenient access to basic Plan information through your smartphone, anywhere, at any time. This includes a virtual copy of your Membership Card.

NAS offers an online member portal allowing you to access a range of services at any time. You can:

- The ability to view, download and send your Membership Card. If your family members are registered under the Plan, you will also be able to access their membership cards.
- Access to the NAS healthcare network directory to search for a Network Provider. This also shows the provider's contact details for you to book appointments, as well as the provider's location, which can be linked to your GPS.
- A platform to communicate directly with NAS.
- Reimbursement claims for dependents and yourself can be submitted and stats for the same can be viewed via myNAS app and there is no financial limit on claims that can be uploaded via app (attachment size maximum 5 MB per file).
- Notification on missing documents will be forwarded via app and resubmission of the documents can be done by opening the notification received.

The myNAS app is available for download from:



This is a free application, designed to support Plan members.

Please refer to the below embedded user manual for myNAS mobile app.



How to use your Medical Plan



Using a Network Facility

Covered treatment at medical providers included in your network is settled by direct billing. This means all you need to do is present your digital Membership Card or Emirates ID if within UAE to the Network Provider on arrival.

Remember, you can access a virtual copy on the myNAS app.

If there is any **Deductible** for out-patient consultations, you will need to pay this directly to the Network Provider at the time of your appointment. You will also need to pay for any **Co-Insurance** and/or any services that are not included in our Plan.

If pre-approval is required for your treatment at a Network facility, this will be arranged by the Network Provider directly with NAS. Network pre-approval requests are usually processed within 24 hours for **In-Patient Treatment** and within 1 hour for **Out-Patient Treatment**.

No pre-approval is required in case of a **Medical Emergency**, but NAS must be informed within 24 hours of the emergency, before discharge.

Using an Out-of-Network Facility

If you use a medical provider that is not included in your network, you will need to pay for the full costs of your treatment (unless you have obtained a Treatment Guarantee from NAS) and submit a reimbursement claim online through the myNAS member portal/myNAS mobile app.

Remember to take a copy of the Claim Reimbursement Form with you to your appointment. This is available to download from the myNAS member portal.

Please note that reimbursement is for covered benefits only, and is based on a percentage of incurred cost. Co-Insurance and Deductibles apply for out-of-network treatment, in line with your Table of Benefits, so you may not be reimbursed the full amount you paid.

If pre-approval is required for your medical treatment, you will need to submit a pre-approval request to NAS before you receive any treatment (**Refer page 3**).

Pre-approval requests are usually processed within 24 hours. Failing to do so will result in denial of your claim.

No pre-approval is required in case of a **Medical Emergency**, but NAS must be informed within 24 hours of the emergency, before discharge.

How to Process a Reimbursement Claim

For all treatment outside the network, you must submit a completed Claim Reimbursement Form. You can download a copy of the Claim Reimbursement Form online through the myNAS portal/myNAS mobile app.

The form must be correctly filled out and signed by you, and also completed with the diagnosis, signature and stamp of your attending doctor.

The fully completed Claim Reimbursement Form must be submitted online through the myNAS portal/myNAS mobile App, together with scanned copies of the following mandatory documents:

- Official receipt for consultation and other billed services
- Breakdown of charges
- Results of lab tests, x-rays and all other examinations performed
- Doctor's prescription for medicines
- Itemised pharmacy bill
- Itemised hospital invoice with the breakdown of service and official receipt for the total amount paid (in case of In-Patient Treatment and Day-Case Treatment)
- Detailed hospital discharge summary report (in case of In-Patient Treatment and Day-Case Treatment)
- Copy of the written approval obtained from the Insurer for any Elective In-Patient Treatment outside of the network in your employment country, or outside of your employment country within the region of cover specified in your Table of Benefits

All claims must be submitted within 180 days from treatment date.



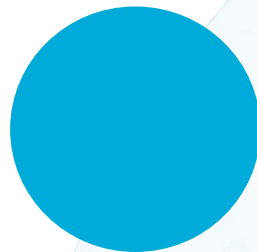
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The original copies of these documents do not need to be submitted at the time of your claim. However, our insurer reserves the right to request the original documents at any point before the claim is processed and settled. Please keep the original documents safe until the claim is settled.

Complete claims will be processed within seven working days. Claims will be reimbursed by bank transfer, if you have included your bank account details on your account through the myNAS portal.

Please note that there will be a delay in processing and settlement of your claim if your Claim Reimbursement Form is not completed correctly and/or if you have not submitted all mandatory documents.

The NAS Contact Center will notify you by e-mail that your claim is incomplete and has been suspended, within 3 working days of your submission, and they will provide details of the additional documents required to process your claim. You must resubmit the additional documents within a maximum of 180 calendar days from the date of the treatment.



Chronic Medication Scheme

NAS offers a Chronic Medication Scheme (CMS), which allows enrolled members to get their regular medication dispensed without consulting their doctor for each prescription. You can enroll for Chronic Medication Scheme via Mobile app as well.

Chronic Medication Scheme

If you have a chronic condition requiring regular medication, simply follow these steps to enrol in the scheme:

1. Contact the NAS Contact Center for a copy of the CMS Enrolment Form.
2. If you are visiting a network doctor, take your completed CMS Enrolment Form to your doctor. Your doctor will fill out a CMS Prescription Form and they will send it directly to the NAS Claims Center, together with your CMS Enrolment Form, to complete your registration application or the same process can be done via mobile app. If you are visiting an out-of-network doctor, you will also need to request a copy of the CMS Prescription Form to take to your appointment. This must be filled out, signed and stamped by your doctor. You must then e-mail the completed CMS Enrolment Form and the completed CMS Prescription Form to the NAS Contact Center or the same process can be done via mobile app.
3. NAS will assess your eligibility for the CMS based on the criteria below.

Please note that you are eligible to be enrolled in the Chronic Medication Scheme only if you meet the following conditions:

- You have an established chronic condition
- Your medication dosage does not need to be changed frequently
- Your follow up visits are only every six months
- Your policy benefit limit is adequate for at least two refills





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When you are enrolled in the CMS, the NAS Contact Center will automatically authorise your medication refill to be collected from your chosen network pharmacy, at an interval of three months.

The NAS Contact Center will e-mail you the prescription authorisation for you take to your chosen network pharmacy to collect your medication. The authorisation is usually issued one week before your new medication is required, and is valid for 10 days. A copy is also sent to your chosen network pharmacy for your convenience. If your medication is not available at your chosen network pharmacy, the closest alternative network pharmacy will be used instead.

Medication is issued for a maximum period of 2-3 months, subject to our policy expiry date and your benefits limits.

Please note that the maximum validity for each CMS prescription is one year, starting from the date of your initial enrolment in the scheme. After one year, you will need to make an appointment with your doctor to evaluate your condition, and then submit a new CMS Prescription Form to the NAS Contact Center.

The NAS Contact Center will send you a reminder to make your follow-up appointment. As an additional service, NAS can pre-arrange this appointment on a date that is convenient for you.



Excluded Healthcare Services



Exclusions For Dubai, Northern Emirates & Outside UAE Members

Unless specified as included under your Table of Benefits, the following expenses are not covered by the Plan.

It is hereby declared and agreed that with effect from 1st August 2020, the following Exclusions, as per the DHA (Dubai Health Authority) Regulations are incorporated herein, unless specified otherwise in the Benefits Schedule.

1. Healthcare Services which are not medically necessary.
2. All expenses relating to dental treatment, dental prostheses, and orthodontic treatments.
3. Care for the sake of travelling.
4. Custodial care including
 - a. Non-medical treatment services;
 - b. Health-related services which do not seek to improve or which do not result in a change in the medical condition of the patient.
5. Services that do not require continuous administration by specialized medical personnel.
6. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies).
7. All cosmetic healthcare services and services associated with replacement of an existing breast implant. Cosmetic operations which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body and breast reconstruction following a mastectomy for cancer are covered.
8. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
9. Medical services utilized for the sake of research, medically non-approved experiments and investigations and pharmacological weight reduction regimens.
10. Healthcare Services that are not performed by Authorized Healthcare Service Providers.
11. Healthcare services and associated expenses for the treatment of alopecia, baldness, hair falling, dandruff or wigs.
12. Health services and supplies for smoking cessation programs and the treatment of nicotine addiction.
13. Treatment and services for contraception
14. 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.
15. External prosthetic devices and medical equipment.
16. Treatments and services arising as a result of professional 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 other professional sports activities.
17. Growth hormone therapy unless medically necessary.
18. Costs associated with hearing tests, prosthetic devices or hearing and vision aids.

19. Mental Health diseases, both out-patient & in-patient treatments, unless it is an emergency condition.
20. Patient treatment supplies (including for example: elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments,) excluding supplies required as a result of Healthcare Services rendered during a Medical Emergency.
21. Allergy testing and desensitization (except testing for allergy towards medications and supplies used in treatment); any physical, psychiatric or psychological examinations or investigations during these examinations.
22. Services rendered by any medical provider who is a relative of the patient for example the Insured person himself or first degree relatives.
23. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during in-patient treatment.
24. Healthcare services for adjustment of spinal subluxation.
25. Healthcare services and treatments by acupuncture; acupressure, hypnotism, massage therapy, aromatherapy, ozone therapy, homeopathic treatments, and all forms of treatment by alternative medicine.
26. All healthcare services & treatments for in-vitro fertilization (IVF), embryo transfer; ovum & sperms transfer.
27. Elective diagnostic services and medical treatment for correction of vision
28. Nasal septum deviation and nasal concha resection.
29. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related investigations, treatments or procedures.
30. Healthcare services, investigations and treatments related to viral hepatitis and associated complications, except for the treatment and services related to Hepatitis A and C.
31. Any services related to birth defects, congenital diseases and deformities unless if left untreated will develop into an emergency.
32. Healthcare services for senile dementia and Alzheimer's disease.
33. Air or terrestrial medical evacuation and unauthorized transportation services.
34. Inpatient treatment received without prior approval from the insurance company including cases of medical emergency that were not notified within 24 hours from the date of admission where possible.
35. Any inpatient treatment, investigations or other procedures, which can be carried out on outpatient basis without jeopardizing the Insured Person's health.
36. Any investigations or health services conducted for non-medical purposes such as investigations related to employment, travel, licensing or insurance purposes.
37. All supplies which are not considered as medical treatments including but not limited to: mouthwash, toothpaste, lozenges, antiseptics, , food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions); and all equipment not primarily intended to improve a medical condition or injury, including but not limited to: air conditioners or air purifying systems, arch supports, exercise equipment and sanitary supplies.
38. More than one consultation or follow up with a medical specialist in a single day unless referred by the treating physician.
39. Health services and associated expenses for organ and tissue transplants, irrespective of whether the Insured Person is a donor or a recipient. This exclusion also applies to follow-up treatments and complications unless if left untreated will develop into an emergency.
40. Any expenses related to immunomodulators and immunotherapy unless medically necessary.
41. Any expenses related to the treatment of sleep related disorders.
42. Services and educational programs for people of determination, this also includes disability types such as but not limited to mental, intellectual, developmental, physical and/or psychological disabilities.

Healthcare services outside the scope of health insurance

1. Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.
2. Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type.
3. Healthcare services for injuries and accidents arising from nuclear or chemical contamination.
4. Injuries resulting from natural disasters, including but not limited to: earthquakes, tornados and any other type of natural disaster.
5. Injuries resulting from criminal acts or resisting authority by the Insured Person.
6. Injuries resulting from a road traffic accident.
7. Healthcare services for work related illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulation of Work Relations, its amendments, and applicable laws in this respect.
8. All cases resulting from the use of alcoholic drinks, controlled substances and drugs and hallucinating substances.
9. Any investigation or treatment not prescribed by a doctor.
10. Injuries resulting from attempted suicide or self-inflicted injuries.
11. Diagnosis and treatment services for complications of exempted illnesses.
12. All healthcare services for internationally and/or locally recognized epidemics.
13. Healthcare services for patients suffering from (and related to the diagnosis and treatment of) HIV – AIDS and its complications and all types of hepatitis except virus A and C hepatitis.



Exclusions For Abu Dhabi Visa Holders

Unless specified as included under your Table of Benefits, the following expenses are not covered by the Plan.

This Schedule sets out the non basic (excluded) healthcare services:

1. Healthcare Services, which are not medically necessary
2. All expenses relating to dental treatment, dental prostheses, and orthodontic treatments. (Aed 1,500 minimum coverage and co-payment Dh 50 maximum)
3. Domiciliary care; private nursing care; care for the sake of travelling.
4. Custodial care includes
 - (1) Non medical treatment services; or
 - (2) Health related services which do not seek to improve or which do not result in a change in the medical condition of the patient.
5. Services which do not require continuous administration by specialized medical personnel.
6. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies).
7. Healthcare Services and associated expenses for replacement of an existing breast implant. Cosmetic operations which improve physical appearance and which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. Breast reconstruction following a mastectomy for cancer is covered.
8. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
9. Medically non-approved experimental, research, investigational healthcare services, treatments, devices and pharmacological regimens.
10. Healthcare Services that are not performed by Authorised Healthcare Service Providers, apart from Healthcare Services rendered in a Medical Emergency.
11. Healthcare services, treatments & associated expenses for alopecia, baldness, hair falling, dandruff or wigs.
12. Supplies, Treatment and services for smoking cessation programs and the treatment of nicotine addiction.
13. Non-medically necessary Amniocentesis
14. Treatment, services and surgeries for sex transformation, sterility and sterilization
15. Treatment and services for contraception
16. Treatment and services related to fertility / sterility (treatment including varicocele / polycystic ovary / ovarian cyst / hormonal disturbances / sexual dysfunction).
17. Prosthetic devices and consumed medical equipments, unless approved by the insurance company
18. Treatments and services arising as a result of hazardous activities, including but not limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any professional sports activities

19. Growth hormone therapy.
20. Costs associated with hearing tests, vision corrections, prosthetic devices or hearing and vision aids.
21. Mental Health diseases, in-patient and out-patient treatments, unless the condition is a transient mental disorder or an acute reaction to stress.
22. Patient treatment supplies (including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments, excluding such supplies required as a result of Healthcare Services rendered during a Medical Emergency).
23. Preventive services, including vaccinations, immunizations, allergy testing and desensitization; any physical, psychiatric or psychological examinations or testing during these examinations.
24. Services rendered by any medical provider relevant of a patient for example the Insured person and the Insured member's family, including spouse, brother, sister, parent or child.
25. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during treatment.
26. 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.
27. Healthcare services and treatments) by acupuncture; acupressure, hypnotism, rolfing, massage therapy, aromatherapy, homeopathic treatments, and all forms of treatment by alternative medicine.
28. All Healthcare services & Treatments for in-vitro fertilization (IVF), embryo transport; ovum and male sperms transport
29. Elective diagnostic services and medical treatment for correction of vision
30. Nasal septum deviation and nasal concha resection.
31. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related test/treatment or procedure.
32. Treatments and services related to viral hepatitis and associated complications, except for treatment and services related to Hepatitis A.
33. Birth defects, Congenital diseases for newborn &/or Deformities unless life-threatening.
34. Healthcare services for Senile dementia and Alzheimer's disease
35. Air or Terrestrial Medical evacuation except for Emergency cases or unauthorised transportation services.
36. Circumcision healthcare services.
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 test or treatment, for purpose other than medical such as tests related for employment, travel, licensing or insurance purposes.
40. All supplies which are not considered as medical treatments including but not limited to: mouthwash, toothpaste, lozenges, antiseptics, milk formulas, food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions) and all equipment not primarily intended to improve a medical condition or injury, including but not limited to air conditioners or air purifying systems, arch supports, convenience items / options, exercise equipment and sanitary supplies.
41. More than one consultation or follow up with a medical specialist in a single day unless referred by a physician.
42. Health services and associated expenses for organ and tissue transplants, irrespective of whether the Insured Person is a donor or recipient.
43. Services and educational program for handicaps.

Schedule No. 3

Healthcare Services outside the Scope of Health Insurance

1. Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.
2. Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type
3. Healthcare services for injuries and accidents arising from nuclear or chemical contamination.
4. Injuries resulting from natural disasters (including but not limited to) earthquakes, tornados and any other type of natural disaster.
5. Injuries resulting from criminal acts or resisting authority by the Insured Person.
6. Healthcare services for patients suffering from AIDS and its complications.
7. Healthcare services for work illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulation of Work Relations, as amended, and applicable laws in this respect.
8. All cases resulting from the use of alcohol, drugs and hallucinatory substances.
9. Any test or treatment not prescribed by a doctor.
10. Injuries resulting from attempted suicide or self-inflicted injuries.
11. Diagnosis and treatment services for complications of exempted illnesses.
12. All healthcare services for internationally and locally recognised epidemics.
13. Venereal sexually transmitted diseases. A list with respect thereto will be set out by the Health Authority – Abu Dhabi.

Useful Definitions & Abbreviations

Useful Definitions

These useful definitions explain some of the important insurance terms used in this guide.

To avoid repetition, the following words or expressions, wherever used in this Policy, have the specific meanings given below.

Accident / Accidental: An injury which is the result of an unexpected event independent of the will of the insured and which arises from a cause outside the individual's control. The cause and symptoms must be medically and objectively definable, allow for a diagnosis and require therapy.

Advice: Any consultation or advice from a General Practitioner or Specialist including the issue of any prescription or repeat prescription.

Anniversary Date: The annual anniversary of the Commencement Date.

Application: The Policyholder's Application / Proposal for cover for the Group under the Policy and, where they are required by us, the individual applications made by Group Members.

Birth Defects or Congenital Conditions: Any deformity or Condition arising during the antenatal stages of Pregnancy or caused by or during Childbirth.

Certificate of Insurance (also see Insurance Certificate): A Certificate addressed to each Group Member giving details of (amongst others) the Date of Entry, Policyholder and the Insured Persons, the Region of cover and extensions, if any.

Chronic Conditions

A disease, illness or injury which has at least one of the following characteristics:

- It continues indefinitely and has no known cure.
- Is recurrent in nature.
- Requires prolonged supervision or monitoring.
- It is permanent.
- The Insured Person needs to be rehabilitated or specially trained to cope with it.

Claim: A new Claim will be incurred for each separate course of eligible Treatment whether required for the same illness or injury or for different illnesses or injuries (whether related or not) and whether or not a new claim form is completed.

Commencement Date: The date shown on the Policy Schedule on which cover for the Group commences under this Policy. For the purposes of the Policy the time of the start of cover under this Policy will be 00.01 a.m. UAE local standard time on the date shown on the Policy Schedule.

Company / Policyholder: The employer and whose name is mentioned in the Policy Schedule.

Complementary / Alternative Medicine: Therapeutic treatment that exists outside the institutions where conventional medicine is taught. Such medicine includes Ayurvedic, Chiropractic, Osteopathy, Acupuncture, Chinese Herbal Medicines, Homeopathy, Podiatry, Speech Therapy and Occupational Therapy practiced by a qualified and licensed therapist

Complications of Childbirth: Refers to the following conditions that arise during childbirth that require a recognised obstetric procedure; post-partum haemorrhage and retained placental membrane. Where the insured's plan also includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.

Complications of Pregnancy: The following conditions that arise during the antenatal stages of pregnancy; ectopic pregnancy, miscarriage, stillbirth, hydatidiform mole.

Co-payment: The percentage of the costs which is payable by the Insured Member and which is to be deducted from the eligible claim amount.

Country of Nationality: For the purposes of this Policy, this will be the country for which an Insured Person holds a passport. For Insured Persons holding more than one passport, the Country of Nationality will be the country from which the Insured Member is expatriated and to which the Insured Person would want to be repatriated.

Country of Residence: The country in which the Insured Person habitually resides at the time this Policy is first taken out, or at each subsequent Anniversary Date.

Date of Entry: The date shown in the Certificate of Insurance on which an Insured Person was included in the Group Policy.

Day-care Treatment: Treatment received in a hospital or day-care facility during the day, including a hospital room and nursing that does not medically require the patient to stay overnight.

Deductible or Excess: That part of the cost which is payable by the Insured Member and which is to be deducted from the eligible claim amount.

Dental Prosthesis: Includes crowns, inlays, on-lays, adhesive reconstructions / restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Drugs and Dressings: Drugs, medicines, dressings, prescribed by a Specialist or Medical Practitioner.

Eligible Dependent(s): A Group Member's spouse or partner and/or unmarried children under 23 years of age who are included in the Group pursuant to the Application and/or Proposal.

Emergency: In the case of an accident or any sudden beginning or worsening of a severe illness resulting in a medical condition that presents an immediate threat to health and therefore requires urgent medical attention. The ATTENDING PHYSICIAN must define the necessary Treatment as EMERGENCY.

Emergency Dental Treatment / Accidental Damage to Natural Teeth: Treatment received in a dental surgery/hospital emergency room for the repair of damage caused in an accident. This does not include any form of dental prosthesis or root canal treatment.

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Evacuation: The transportation of an Insured Person from the country of incident, to the nearest appropriate facility, as determined by an Insured Person's Medical Practitioner or Specialist in conjunction with our medical advisers and the prescribed Assistance Company, for the sole purpose of receipt of Treatment as an in-patient or day-patient.

Group: All Insured Persons covered under this Policy pursuant to the Application / Proposal.

Group Member(s): An employee of the Policyholder who is designated as being eligible for inclusion in the Group in accordance with the terms of the Policy.

Hospital: An establishment, which is licensed as a medical or surgical facility in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered as hospitals: rest and nursing homes, spas, cure-centers and health resorts.

Infertility Treatment: Treatment for both sexes including investigative procedures up to the point of diagnosis only.

In-patient Cash Benefit: Is payable when treatment and accommodation for a medical condition that would otherwise be covered under the Policy is provided in a hospital where no charges are billed. Cover is limited to the amount specified in the Benefit Schedule and is payable upon discharge from hospital.

In-patient Treatment: Treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate (also see Certificate of Insurance): A Certificate addressed to each Group Member giving details of (amongst others) the Date of Entry, Policyholder and the Insured Persons, the Region of cover and extensions, if any.

Insured Person: A Group Member or Eligible Dependent included in the Application / Proposal or subsequently added to the Policy by declaration.

Local Ambulance: Road ambulance transport, required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

Major Fluctuation: Any change in the Membership of 10% or more from the Membership applicable on the Commencement Date or, if later, the appropriate Anniversary Date or last preceding Major Fluctuation.

Medical Practitioner: A physician who is licensed under the law of the country in which treatment is given, to practice medicine and where he/she is practicing within the limits of his/her license.

Membership: The number of Group Members on cover by category of risk, indicating level of cover, age, whether single, married, family or single parent family as set out on the Policy Schedule.

Network Provider: A Hospital, pharmacy, medical or dental facility, or Treatment provider appearing on the Network List, as selected and stated on the Policy Schedule and the Insured Member's Insurance Certificate.

Newborn Care: Forms part of the Routine Maternity Benefit and includes circumcision, customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow up investigations and treatment are only covered under the newborn's own policy.

Nursing at Home: The medical services of a registered nurse as prescribed by a physician in the Insured Person's home immediately after or instead of in-patient or day-care treatment.

Oncology: Specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis.

Opening Membership: The Membership on the first day of the Policy Period.

Orthodontic Treatment: Procedures required to diagnose or treat malocclusion and irregularities of the teeth.

Organ transplantation: The surgical procedure in performing the following organ and/or tissue transplants; heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular / skeletal and cornea transplants. Expenses incurred in the acquisition of organs are not covered.

Out-patient surgery: Is a surgical procedure performed in a doctor's surgery, hospital, day-care facility or out-patient department that does not require the patient to stay overnight out of medical necessity.

Out-patient treatment: Treatment provided in the practice or surgery of a Medical Practitioner, Specialist or Therapist that does not require the patient to be admitted to hospital.

Palliative Treatment: A medical procedure, the primary purpose of which is to offer only temporary relief of a condition's symptoms, rather than to cure the actual medical condition causing the symptoms.

Periodontic Treatment: Procedures required to diagnose or treat diseases of the periodontium.

Policy: The Contract of insurance with the Company / Policyholder providing cover for Group Members and their Eligible Dependents as detailed in the Policy document. The Application / Proposal, Policy Schedule and Benefits Schedule form part of the contract and must be read together with this Policy document (as may be amended from time to time).

Policy Schedule: A schedule in the Policy document providing a summary of the Insured Members, Regions of Cover, Networks and applicable premiums.

Policyholder/you/your: The Company or other business entity named as the Insured / Policyholder in the Policy Schedule.

Policy Period: The period set out in the Policy Schedule during which cover is in place and for which the premium has been paid.

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Pre-existing conditions: Medical conditions or any related conditions, for which symptom(s) have been shown at some point during the 3 years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing. Your Policy covers pre-existing conditions.

Pregnancy and Childbirth: Childbirth, miscarriage and termination (including pre- and post-natal check-ups and delivery costs).

Premium(s): The rates payable for single, married, family or single parent family covered under the Policy.

Prescribed Glasses and Contact Lenses: Refers to cover for an eye examination carried out by an optometrist or ophthalmologist (one per Policy Period) and for lenses or glasses prescribed to correct vision.

Prescribed Physiotherapy: Treatment by a registered physiotherapist following referral by a Medical Practitioner. Physiotherapy is initially restricted to 25 sessions per condition, after which the treatment must be reviewed by the referring Medical Practitioner. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment.

Preventive Treatment: Treatment that is undertaken without any clinical symptoms being present at the time of treatment.

Psychiatry and psychotherapy: Treatment of a mental or nervous disorder carried out by a clinical Psychiatrist or clinical Psychologist.

Qualified Nurse: A qualified resident or daily nurse whose name is currently on any register of nurses maintained by any statutory nursing registration body within the country in which he/she is resident.

Region: The Region of the world for which the Policyholder has selected cover in respect of an Insured Person. This Region represents where you can choose to go for ELECTIVE TREATMENT.

Related: Illnesses or injuries are related if, in our reasonable medical opinion, one is a result of the other or if each is a result of the same illness or injury.

Routine Dental Treatment: Routine treatment including examinations, tooth cleaning, scaling, polishing, normal compound fillings, extractions, X-rays and surgery received in a dental surgery.

Specialist: A qualified and licensed Medical Physician possessing the necessary additional qualifications and expertise to practice as a recognised Specialist of diagnostic techniques, treatment and prevention in a particular field of medicine, including but not limited to neurology, paediatrics, endocrinology, obstetrics, gynaecology and dermatology.

Therapist: An Ayurvedic Chiropractor, Osteopath, Acupuncturist, Chinese Herbal Therapist, Homeopath, Podiatrist, Speech and Occupational Therapist, Physiotherapist, who is qualified and licensed under the law of the country in which treatment is being given.

Treatment: Surgical or medical procedures the sole purpose of which is the cure or relief of acute illness or injury. An acute illness or injury is characterised by an occurrence of brief duration after which the Insured Person returns to his/her normal or previous state and degree of activity.

Treatment Date: The actual date of the Treatment.

Useful Abbreviations

The following abbreviations may be used on the membership card:

CN:	Comprehensive Network
GN:	General Network
RN:	Restricted Network
IN:	In-Patient treatment
OUT:	Out-Patient treatment
D:	Deductible
CO:	Co-pay/Co-participation
CAT:	Category
DB:	Dental Benefit
MB:	Maternity Benefit



Frequently Asked Questions



How can I understand the detail of benefits covered under the policy?

If you choose to visit an out-of-network facility, all expenses will be on a reimbursement basis only. This means you will need to pay the provider for the full costs of your treatment, then submit a Claims Reimbursement Form to NAS for reimbursement. Information on how to submit a claim is provided later in this guide.

What if the treatment I need is not available within my network?

If the treatment you need is not available at any Network Provider, the NAS Contact Center will help you to make alternative arrangements to access your required treatment.



What is the hospital network coverage of the insurance plan? Where can I find the list of hospitals that are included within the policy?

The members can access the network list using the Health Hub Suite, which is the latest addition to the myNAS mobile application. The digital solution offers a seamless and user-friendly experience to patients and a smart tool for payers to encourage responsible provision of healthcare. The platform contains your network information, policy benefits and coverage.

What is pre-approval? Who is responsible for getting the pre-approval?

Pre-approval is required before a planned treatment to ensure that the treatment is covered under the policy and assurance is received from the insurance company that incurred costs will be paid as per terms and conditions agreed. Within the network it is the responsibility of the hospital to get the approval, outside the network it is the responsibility of the member to get the approval. The member can contact the NAS Contact Center number or write to them at claimcenter@nas.ae. Alternately they can also write to Helpdesk.Dubai@mercermarshbenefits.com.



Who can I contact if I have a question that isn't covered in this guide?

If you have any additional questions on the Plan, your medical benefits or your network, please contact the NAS Contact Center using the contact details provided under the Member Services section.

You can also contact Mercer Marsh (your brokers) for assistance. The MercerMarshBenefits Helpdesk number is +971 (0)4 212 9200 or, if you are in the UAE, you can call the toll-free number on 800-MARSH (62774). The MercerMarshBenefits Helpdesk is available on weekdays from 8am to 5pm, and can also be contacted by email on Helpdesk.Dubai@mercermarshbenefits.com.

How do I submit reimbursement claims?

The member will have to pay for the treatment and claim the same. Members need to fill in the reimbursement forms and submit the same along with the original invoice and medical reports. Members can submit the reimbursement claims along with the claim form, medical report, original invoice and breakdown of itemized bills through the myNAS portal or the myNAS mobile App.

What should I do if I have a problem uploading my claim to the myNAS portal?

If you have any problems logging in to the myNAS portal or uploading your claims, please e-mail the NAS Contact Center for assistance, including a screen shot of the error message and a scanned copy of your completed claim documents.

Why would a claim be declined?

A claim may be declined due to the reason that proper documents were not submitted for reimbursement. A claim may also be declined since the condition may not be a covered condition as per the policy terms and conditions. The reason would be provided on the explanation of benefit form from the insurer. In case of further query on the same the MercerMarsh help desk number may be contacted.

