Proposal for	BASIC PLAN		
date created	03-01-2017	**quoting reference no.**	

Section 1: *Your Benefits*

class name :

plan	
Area of cover	UAE (Excluding the Emirate of Abu Dhabi & Al Ain Region). Emergency extension to UAE; Home country (Excluding USA & Canada) Covered for IP subject to UAE R&C selected Network rates and with prior-approval.
Annual financial limit pppy	AED 150,000 (including any coinsurance and/or deductibles)
Number of employees	
Network	IRIS – EZYCLAIM NETWORK: Out-patient treatments are restricted to clinics only. In-patient treatments are restricted to hospitals only.
Note	Further to eligibility of cover: • Dependents are covered • Employees with salary up to maximum of AED 4,000 • Age from 0-65 years only. Above 65 years, will be subject to underwriting unless opting for basic plan with less than AED 4000 salary. • Parents and Partners are not included under this plan • Not applicable for any associations/medical providers/schools/school teachers/ Doctors/ Nurses (unless opting for basic plan with less than 4000 salary).
Hospital room type	Ward Room

Eligibility of cover	• Employees only (Dependents excluded) • Employees drawing salary less than AED 4,000/ • Employees holding valid Dubai Visas / Northern Emirate, excluding Abu Dhabi & Al Ain.
Reimbursement Claims	**Emergency** - Outside Network & Govt Hospitals (IP&OP) - Covered 100% Subject To UAE Selected Network Tarrif. **Elective** - Outside Network & Govt Hospitals (IP&OP)-Not Covered
Pre-existing & Chronic conditions (In-patient & Out-patient combined) Note: Where a pre-existing or chronic condition develops into an emergency within the 6 month exclusion period it will be covered up to the annual aggregate limit	Covered with 20 % co-insurance
In-patient and Day-patient	
Room and board costs for hospitalisation	Covered with 20 % coinsurance Co insurance payable by the insured with a cap of AED 500 payable per encounter and an annual aggregate cap of AED 1,000. Above the cap
Tests, diagnosis, treatments and surgeries in hospitals for non-urgent medical cases (prior approval required from RAK Insurance).	Covered with 20 % coinsurance Co insurance payable by the insured with a cap of AED 500 payable per encounter and an annual aggregate cap of AED 1,000. Above the cap
Tests, diagnosis, treatments and surgeries in hospitals for emergency treatment (approval required from RAK Insurance within 24 hours of admission to the authorized hospital).	Covered with 20 % coinsurance Co insurance payable by the insured with a cap of AED 500 payable per encounter and an annual aggregate cap of AED 1,000. Above the cap
Healthcare services for emergency cases.	Covered with 20 % coinsurance Co insurance payable by the insured with a cap of AED 500 payable per encounter and an annual aggregate cap of AED 1,000. Above the cap
Ground transportation service in the UAE provided by an authorised party for medical emergencies	Covered with 20 % coinsurance Co insurance payable by the insured with a cap of AED 500 payable per encounter and an annual aggregate cap of AED 1,000. Above the cap
The cost of accommodating a person accompanying an insured child up to 16 years old.	Covered Maximum AED 100 per night
The cost of accommodation of accompanying an in-patient in the same room in cases of medical necessity at the recommendation of the treating doctor and after the prior approval of RAK Insurance.	Covered Maximum AED 100 per night
Out –patient Benefits	

Examination, diagnostic and treatment services by authorised general practitioners, specialists and consultants.	Covered 20% up to maximum of AED 25 Referral Procedure: No treatment may be provided by specialists or consultants without the insured first consulting a General Practitioner Licensed by DHA or another competent UAE Authority.
Laboratory test services carried out in the authorised facility assigned to treat the insured person.	Covered with 20 % coinsurance
Radiology diagnostic services carried out in the authorised facility assigned to treat the insured person (non-emergency RAK Insurance's prior approval is required for MRI, CT Scans and endoscopies)	Covered with 20 % coinsurance
Physiotherapy treatment services (prior approval of RAK Insurance is required)	Covered with 20 % coinsurance (up to 6 sessions per person per year)
Drugs and other medicines	Covered up to AED 1,500 PPPY 30% co-insurance Covered up to the above annual limit subject to co-insurance for each and every prescription (restricted to a list of formulary products to be Published by DHA).
Maternity Benefits	
Maternity Services (Outpatient ante-natal services) (requires prior approval from RAK Insurance) Note: Where any condition develops which becomes life threatening to either the mother or the new born, the medically necessary expenses will be covered up to the annual aggregate limit.	Covered 10% co-insurance • 8 visits to Public Health clinics. • All care provided by Public Health Clinics obstetrician for low risk or specialist obstetrician for high risk referrals. • Initial investigations to include: • FBC and platelets • Blood group, Rhesus status and antibodies • VDRL • MSU & urinalysis • Rubella serology • HIV • Hep C offered to high risk patient • GTT if high risk • FBS, randoms or A1c for all due to high prevalence of diabetes in UAE. • Visits to include reviews, checks and tests in accordance with DHA ante-natal care protocols. • 3 ante-natal ultrasound scans.
In patient maternity services (requires prior approval from RAK Insurance or within 24 hours of emergency treatment)	Covered up to AED 10,000 PPPY 10% co-insurance Co-insurance payable by the insured. Maximum benefit AED 7,000 per normal delivery, AED 10,000 for medically necessary C-section, complications and for medically necessary termination (all limits included co-insurance).
Other Benefits	

Essential vaccinations and inoculations for new borns and children as stipulated in the DHA's policies and its updates in the assigned facilities.	Covered Only available for services administered at DHA facilities.
Preventive services as stipulated by DHA to initially include diabetes screening.	Covered Frequency restricted to: Diabetes: - Every 3 years from age 30. - High risk individuals annually from age 18.
Medical emergencies on diagnostic and treatment services for dental and gum treatments.	Covered 20% co-insurance
Medical emergencies on hearing and vision aids, and vision correction by surgeries and laser.	Covered 20% co-insurance
New born cover	Covered • Cover for 30 days from birth. • BCG, Hepatitis and neo-natal screening tests. (Phenylketonuria (PKU), Congenital Hypothyroidism, sickle cell screening, congenital adrenal hyperplasia)

Premium Schedule

Class Name :

***UAEDIRHMS*-PER PERSON PER YEAR**			
Age Band	No. Of Members	AED -Rate PPPY	AED - Total Premium
0-65		565	
Grand Total			

Notes:

- We reserve our rights to amend terms, rates and conditions in case of risk findings reveals misrepresented or undisclosed material facts that could affect the decision of the Underwriters
- The schedule of benefit above will override the General Exclusion list below
- Quoted network is subject to revision.
- E. & O.E.

Section 2: ***General Conditions and Procedures***

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

or category of the persons to be insured or the scope of coverage will result in recalculation of the premium rates and benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

35 - Change of category is not allowed during the policy period unless the member's internal status has changed in the company like promotion or salary change. Any such change would need supporting documents like promotion letter,change in contract etc

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

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

Section 3: Healthcare services outside the scope of health insurance (*Exclusions*)

1. Healthcare Services, which are not medically necessary.

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

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

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

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

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

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

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

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

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

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

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

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

14. Treatment and services for contraception.

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

16. External Prosthetic devices and medical equipment.

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

18. Growth hormone therapy.

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

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

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

22. Allergy testing and desensitization (except testing for allergy towards medications and supplies used in treatment); any physical, psychiatric or psychological examinations or investigations during these examinations.

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

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

25. Healthcare services for adjustment of spinal subluxation.

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

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

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

29. Nasal septum deviation and nasal concha resection.

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

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

32. Birth defects, congenital diseases and deformities.

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

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

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

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

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

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

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

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

41. Any expenses related to immunomodulators and immunotherapy.

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

43. Services and educational programs for handicaps.

DHA Exclusions-2

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

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

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

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

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

6) Injuries resulting from a road traffic accident.

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

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

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

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

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

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

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

Healthcare services outside the scope of health insurance.

Section 4: How to make reimbursement claims-If applicable

*please refer to attached claim form

Claim Center Role

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

Group Medical Policy Standard Claim Procedures

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

   Within UAE:

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

   2.2 Original supporting documents to be provided for any medical claim are:

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

   Outside UAE:

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

   2.4 All original supporting documents as mentioned above to be provided for any medical claim. Exclusively a medical report specifying whether the treatment was an elective or emergency treatment with the medical condition briefly explained to evaluate the extent of coverage.

3. TPA may, upon the evaluation of each case, grant or deny the coverage based on the Terms, Conditions, Limitations and Exclusion of the Policy.
4. Documents will be forwarded for TPA evaluation which extends to period of 3-4 weeks. On receipt of the evaluation sheet we proceed for the settlement of the claim.
5. **Mode of settlement for medical reimbursement claim:**

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

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

   5.3 The reimbursement of all claims will be effected in the United Arab Emirates Dirhams (AED) or

USD equivalent (converted at the exchange rate applicable at the date evidenced by the bill) whenever the insured has paid the expenses of the claim, subject of the reimbursement, in a foreign currency.

6. For Direct Network:

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

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

Approval of Coverage

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

Procedures of Approval

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

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

Pre-Approval for Diagnostic / Therapeutic Procedures

• Angiography	• IVP
• Arthogram	• Mammogram
• Barium Studies	• MCU
• All Endoscopies	• MRI
• CT-Scans	• Myelogram
• Doppler Studies	• Oral Cholecystogram
• Echocardiography	• Pap smear
• EEG	• Rubella tests
• EMG	• Stress Tests
• Excretory Urography	• Thyroid function tests
• FNAC	• Toxoplasma tests

- Holter monitoring

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

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

Individual Medical Policy Standard Claim Procedures

Claim submitted directly to TPA

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

Claim submitted directly to RAK Insurance

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

Section 5: *Your Medical Networks*

Network

As per the attached list

How to use the Network:

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

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

When is pre-approval required?

For Out-Patient

Refer to prior approval table in section 1

For In-Patient

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

Other Services

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

Pre-approval requirements

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

Emergencies

- Within 24 hours or prior to discharge