Schedule of Benefits – Flexi Health Insurance Plan

Plan Name	**Flexi Health Insurance Plan**
Annual Benefit Limit	AED 150,000 Per Person Per Policy Year
Territorial Limit	Emirate of Abu Dhabi Outside Emirates of Abu Dhabi (Within UAE): Emergency Cover only
Network (Allowing direct billing at designated providers)	**Flexi NW** • Network Clinics/Primary Healthcare Centres (PHC) – Outpatient treatment and GP consultation. No costs incurred for advice, consultations or treatments provided by specialists or consultants shall be covered under this plan without the Eligible Person first consulting a General Practitioner (GP) who is licensed by DOH. The GP must make his referral together with reasons via the electronic system for the claim to be considered. • Network Hospitals: In Network hospitals, plan offers coverage only for inpatient and emergency treatment. Outpatient treatment in network hospitals is not covered unless referred by a network General Practitioner (GP) in clinics for advice/consultation by a specialists / consultant at hospitals with justifications via the electronic system for services not available in Flexi network clinics/PHC.
Pre-existing conditions	• Pre-existing conditions are covered only if declared on the application form. • Covered with 6 months waiting period. The waiting period applies to Inpatient treatment only for the following medical conditions: Diabetes mellitus, Arterial diseases, COPD (Chronic Obstructive Pulmonary Disease), All cancers cases, Neurosurgery, Cerebro Vascular diseases, All delivery cases. • No waiting period applicable if pre-requisition of uninterrupted (pre-) coverage is fulfilled.

Inpatient Treatment	**Network**	**Non-network[5]**
Inpatient & Day Treatment[1] Up to the relevant annual benefit limit Per Person (Including Pre & Post in Hospital Treatment Covered) (Out of pocket limit of AED 500 per encounter and an annual aggregate limit of AED 1,000)	80% covered	Not covered
Accommodation Type- General Room (2+beds)	80% covered	Not covered
Hospital Accommodation & Services	80% covered	Not covered
Consultant's, Surgeon's & Anesthetist's Fees and other fee	80% covered	Not covered
Ambulance Services (in Medical emergency only, subject to General exclusions)	100% covered	100% covered[6]
Parent Accommodation for accompanying an Insured Child under 16 years of age (Maximum limit of AED 100 per day)	80% covered	Not covered
Companion Accommodation in cases of medical necessity at the recommendation of the treating doctor (Maximum limit of AED 100 per day)	80% covered	Not covered
Out-patient Treatment	**Network**	**Non-network[5]**
Physician Consultation (Access to outpatient specialists/consultants only upon referral by GP from Flexi Network Providers (Clinics/PHC) with justifications via the electronic system) (Coinsurance not applicable for follow up within 7 days)	GP - 80% covered Specialist – 100% covered	Not covered
Diagnostics (X-Ray, MRI, CT-Scan, Ultrasound, etc.), Laboratory (Specialized investigations and scans including but not limited to MRI, Scan, Endoscopies with Pre-authorization only)	80% covered	Not covered
Pharmaceuticals (Annual Limit Per Person of AED 1,500 inclusive of Coinsurance) (Restricted to Basic formulary drugs)	70% covered	Not covered
Physiotherapy[1] (Maximum up to 6 sessions per year)	80% covered	Not covered
Vaccines and immunizations[2]	80% covered	Not covered[5]
Other Benefits	**Network**	**Non-network**
Emergency Treatment in UAE	100% covered	100% covered[6]
Diagnostic and treatment services for dental and gum treatment (Medical emergency cases)	80% covered	80% covered[6]
Hearing and vision aids, and vision correction by surgeries and laser (Medical emergency cases)	80% covered	80% covered[6]
Maternity[1,3]	**Network**	**Non-network[5]**
Inpatient Maternity Maximum Annual benefit limit per delivery (inclusive of Coinsurance): • Normal delivery: AED 7,000 • Caesarian section, complications, and medically necessary termination: AED 10,000 • Newborn Care: Up to 30 days from birth (Newborn care to include BCG, Hepatitis B and neo-natal screening tests)	90% covered	Not covered
Outpatient Maternity[4] (Coinsurance not applicable for follow up within 7 days)	90% covered	Not covered

1. Preauthorization required to avail this benefit. All Emergency cases do not require pre-authorization but should be notified to Daman within 24 hours.
2. Covered on reimbursement basis only. Essential vaccinations for newborns and children as stipulated in MOHAP's policies and any updates thereto.
3. Maternity: Where any condition develops into life threatening to either the mother or the newborn, the medically necessary expenses will be covered up to the annual aggregate limit.
4. Outpatient maternity includes: (1) 8 visits to Primary Health Centre (PHC) reviews, checks and tests in accordance with the Antenatal Care Protocols; (2) All care provided by PHC obstetrician for low risk or specialist obstetrician for high-risk referrals.
5. Elective treatment at non-network Government Hospitals, 80% of actuals covered subject to maximum of 100% of applicable network rates. Treatment at non-network Government Hospitals covered on reimbursement basis.
6. Emergency Treatment at non-network providers covered on reimbursement basis.

IMPORTANT TO KNOW

Annual Benefit Limit
The maximum amount paid by Daman under the terms and conditions of this Policy.
Certain benefits under the plan will have its own benefit limits and member share. All benefits together will not exceed plan Annual Benefit Limit.

Territorial Limit
The identified geographical area for elective / emergency treatments within which Health Services are covered under the Policy.

Network
When used to describe a Provider of Health Services that has a participation agreement in effect with Daman, to provide Health Services to Eligible Persons on direct billing. Eligible Persons are required to verify the participation status of a Physician, Hospital or other Health Services as the participation status of a Provider may change from time to time. Eligible Persons can verify the participation status from the Daman website/mobile application or by calling the customer care centre at Daman.

Non-Network
When used to describe a Provider of Health Services that is not part of the plan Network. Treatment availed at non-network providers is not covered unless specifically mentioned in the SOB.

Pre-existing conditions
Any known injury, illness, sickness, disease or other medical condition, disorder or ailment that existed at the time of application including any subsequent complications or consequences related thereto or arising there from. Pre-existing conditions are covered only if declared on the application form.

Consultation (Access to outpatient specialists/consultants only upon referral by GP in clinics/PHC with justifications via the electronic system)
No costs incurred for advice, consultations or treatments provided by specialists or consultants shall be covered under this plan without the Eligible Person first consulting a General Practitioner (GP) who is licensed by DOH. The GP must make his referral together with reasons via the electronic system for the claim to be considered.

Basic formulary drugs
The list is published and mandated by Department of Health (DOH). Only drugs part of "Basic formulary drugs" are covered under the plan. Drugs not part of the Basic formulary drugs are not covered under the plan and member has to pay for it.

Inclusive of co-insurance
Means maximum benefit limit payable by Daman after deducting member share.
[For example: Outpatient Pharmaceuticals (Annual limit of AED 1,500 per person inclusive of co-insurance, covered 70% (30% coinsurance) at Network)]

Pharmaceuticals: 70% inclusive of co-insurance	*Annual Limit per person: AED 1,500* *(Daman's maximum share inclusive of co-insurance: 70% of AED 1,500 = AED 1,050)*		
	Daman Share (70%)	***Member Share (30%)***	**Remaining Balance**
1st Bill Amount: AED 1,000	AED 700	AED 300	AED 500 {AED 1000 – (AED 700 Daman share + AED 300 Member Share)}
2nd Bill Amount: AED 500	AED 350	AED 150	AED 0 {AED 500 – (AED 350 Daman share + AED 150 Member Share)}

3rd Bill Amount: AED 200	AED 0*	AED 200	Benefit limit already exhausted
Total	AED 1,050	AED 650	
	*Since benefit offered is inclusive of 30% coinsurance, Daman has already paid out the full AED 1,050 annual benefit limit, Daman will not pay any other claim and member will have to pay for the entire expense.		

Out of Pocket limit (OOP)
Means maximum amount payable by an Eligible Person for availing a covered Health Service.
[For example: Inpatient treatment (80% covered at network providers (20% coinsurance) with Out-of-pocket limit of AED 500 per encounter and an annual aggregate limit of AED 1,000)

Scenarios samples	***Member Share (Per encounter limit AED 1,000)***	***Member Share (Annual Aggregate Limit AED 1,000)***	***Daman Share***
1st inpatient encounter *Bill amount: AED 10,000*	20%: AED 2,000	Limit utilised – AED 500	Daman pays: AED 9,500 as member per encounter limit AED 500
	Member pays: AED 500	Balance AED 500	
2nd inpatient encounter *Bill amount: AED 1,000*	20%: AED 200	Limit utilised – AED 500+200 = 700	80%: AED 800
	Member pays: AED 200 (as ember share is lower than OOP limit)	Balance AED 300	
3rd encounter *Bill amount: AED 5,000*	20%: AED 1,000	Limit utilised -1000 (500+200+300)	Daman pays: AED 4,700
	Member pays: AED 300 (as annual aggregate limit AED 1,000)	Balance AED 0	
4th encounter *Bill amount: AED 2,000*	Member pays: AED 0*	Balance AED 0	Daman pays: AED 2,000
	*After the member has paid out the aggregate annual limit of AED 1,000, the member will not have to pay any further co-insurance for all succeeding inpatient treatments.		

Emergency
A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.

Preauthorization
Pre-authorisation is required for any non-Emergency Hospitalisation (medical and/or surgical and/or maternity related) as well as for other Outpatient services as specified in the schedule of benefits. Emergency cases do not require prior approval but should be notified to Daman within 24 hours.

Reimbursement
Where medical treatment or service availed outside of the plan's network providers, or if the benefit is offered on reimbursement basis; then Eligible Person need to pay for the service and claim the amount via reimbursement.

Direct billing
Cashless treatment at Network providers, where bills will be settled directly by Daman. However, Eligible Person's remains liable for payment of the Co-insurance specified in the Schedule of Benefits.

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