
mednet
Care
you feel.
Integrity
you trust.

Welcome to the MedNet Family!

We understand that health insurance can sometimes feel overwhelming, and we're here to make things easier for you by helping you better understand your coverage and the services available to you.

Inside, you will find clear, easy-to-follow information about your benefits and how to access care. If you ever need assistance, our dedicated team is always here to help.

Who we are?

MedNet is a licensed Third-Party Administrator (TPA) that provides administrative services for health insurance policies on behalf of insurance companies.

We act as a bridge between members, healthcare providers, and insurers, managing processes such as claims administration, pre-approvals, and the coordination of medical services. The funding and payment of eligible claims, however, remain the responsibility of the insurance company.

Through our network of partner hospitals, clinics, and healthcare providers, we facilitate efficient access to healthcare services in accordance with the terms, conditions, and benefits of your insurance coverage.

How Do I Know If I Am Insured Through MedNet Services?

After your insurance policy becomes active, you should receive confirmation from your insurer or, if you are covered under a group policy, from your employer or HR team. Depending on your policy and the enrolment process, this may include your electronic insurance card (e-card), Table of Benefits (TOB), and other policy documents. If your e-card is provided as a secure attachment, you may be asked to enter your date of birth to open it.

If you purchased your policy online, your policy documents and e-card are typically issued once your policy has been activated.

The timing and method of these communications may vary depending on your insurer and policy. If you have any questions about your coverage or have not received your policy documents, please contact your insurer or your employer's HR team.

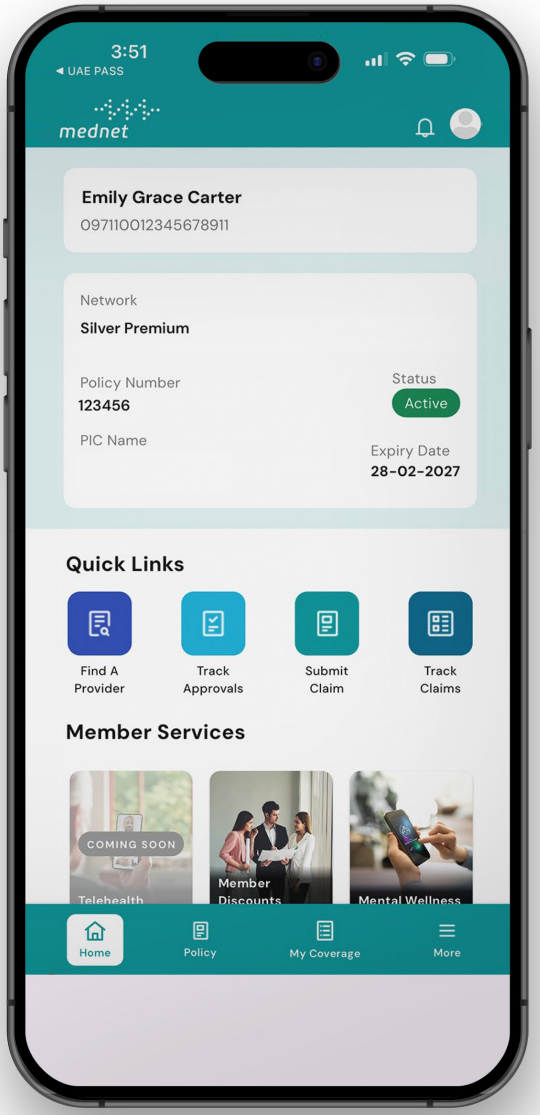
MyHealthPass App and Member Portal Overview

The MyHealthPass App and Member Portal provide easy access to your health insurance coverage and benefits. Through both platforms, you can:

Digital ID Card
View and download your insurance card anytime

Find a Doctor
Search providers and book appointments

Submit & Track Claims
Submit claims and monitor their status in real time



Track Approvals
Check approval status anytime through the app or portal

Family Access
Access your family's health insurance services

Support
Contact our customer service team whenever you need help

mednet

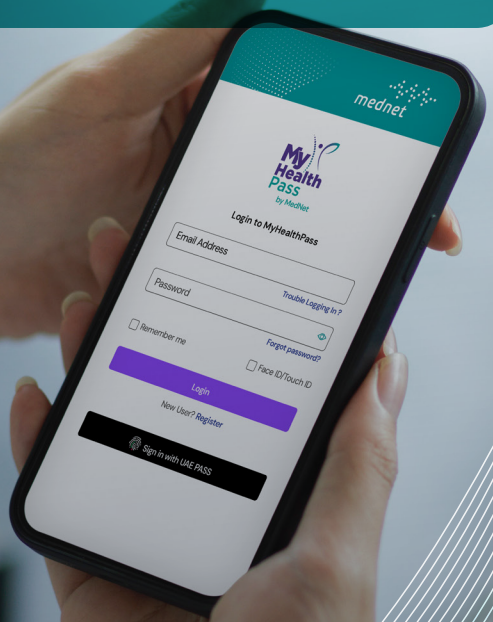
How to register?

Get started with your online registration and manage your healthcare benefits anytime, anywhere.

You can register easily through the MyHealthPass App or Member Portal using a single username and password. For added convenience, you may also register using your Emirates ID.

Simply download the MyHealthPass App from Google Play or the App Store to access MedNet services at your fingertips.

The application is accessible across multiple countries, allowing you to conveniently manage your healthcare benefits while at home or abroad.



My Health Pass by MedNet

Download the app here

How Do I Log In After Registration?

Once you have successfully completed the registration process, you can access your account via the app or the portal by using any of the following methods

Username and Password
Enter the username and password you created during registration, then select Sign In.

Face Enable
If you activated facial recognition during registration, you can use this option to log in securely.

UAE PASS
Select UAE PASS and follow the authentication steps to securely access your account.

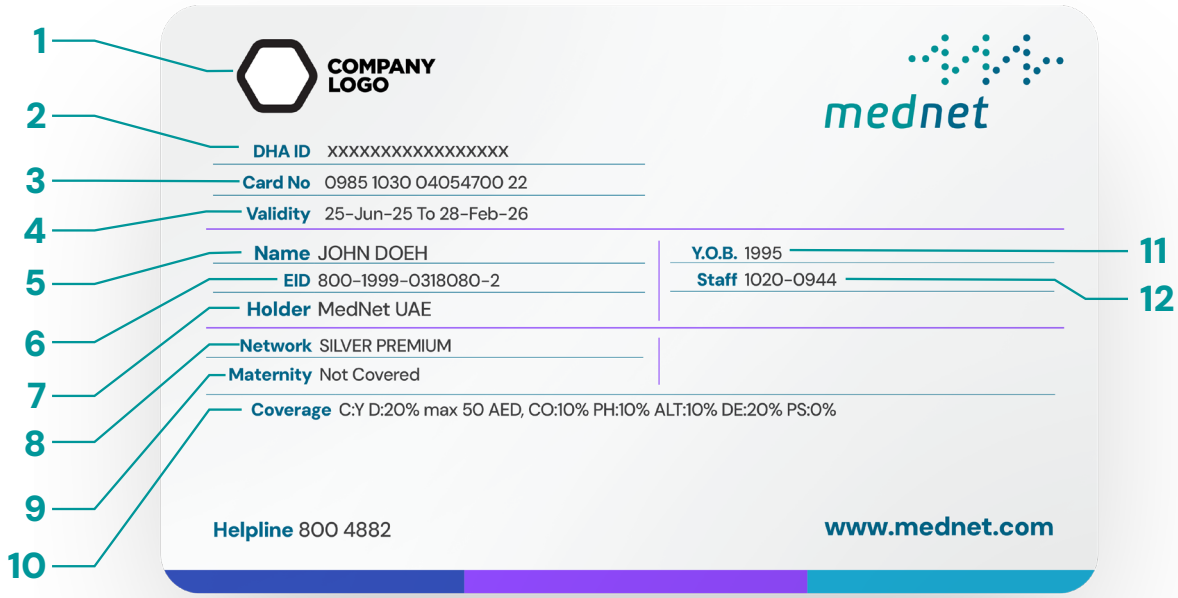
For more information on registration and login features, please refer to the MyHealthPass Member Guide
https://mednet.com/web-assets/pdfs/MyHealthPass-User-Guide.pdf

Forgot Your Password?
If you have forgotten your password, select Forgot Password on the login screen and follow the on-screen instructions to reset it.

Insurance Card

Download your insurance card from the MyHealthPass app or Member portal to get an overview of your main benefits at a glance.

Let's proceed with the information on your insurance card.



1. **Insurer's Logo** The logo of your insurance provider.
2. **DHA or DoH ID** Your regulatory health insurance ID issued by the relevant authority.
3. **Card Number** Your insurance card number.
4. **Validity** Your policy coverage period.
5. **Name** Your full name.
6. **EID** Your Emirates ID number.
7. **Policy Holder** The name of the policy holder.
8. **Network** The healthcare provider network applicable to your policy.
9. **Maternity** Indicates whether maternity is covered, including any applicable deductibles and co-payments.
10. **Coverage** A summary of your benefits, including:

    IP In-Patient
    OP Out-Patient
    PH Pharmacy
    CS Consultation
    DE Dental
    CH Chronic
    PS Preventive Screening
    MT Maternity

    This section also shows any applicable patient share, such as 0%, 10%, or 20% deductible or co-payment, depending on your policy.
11. **Year of Birth (YOB)** Your year of birth.
12. **Staff ID** The staff ID assigned by your insurer for your group policy, if applicable.

mednet

Understanding your insurance coverage

We will guide you through the key details of your insurance coverage, including the essential insurance terms you should be familiar with.

Your health insurance policy is designed to provide financial protection for eligible medical expenses and healthcare services covered under your plan.

Coverage is available for treatments and services that are supported by accepted medical evidence and, where applicable, are subject to review by the medical team. Covered treatments and services must be:

- Medically necessary.
- Appropriate for the diagnosis or treatment of a medical condition.
- Consistent with generally accepted medical standards.

The specific benefits, coverage limits, exclusions, and any applicable conditions are detailed in your Table of Benefits and policy documentation.

If you have any questions about your coverage, we recommend contacting us before receiving treatment. We will be pleased to confirm whether a particular treatment, service, or benefit is covered, subject to the terms, conditions, limitations, and exclusions of your policy.

Table of Benefits (TOB)

The Table of Benefits (TOB) outlines the healthcare services covered under your health insurance plan, together with the applicable limits, co-payments, deductibles, and any specific conditions of coverage.

You can easily view a sample summary of coverage details through the My Coverage tab in the MyHealthPass by MedNet mobile app or Member Portal. This section provides a clear overview of the services included in your plan, along with any applicable limits and member cost-sharing requirements.

If you require a copy of your full Table of Benefits (TOB), please contact your HR department if you are covered under a group policy, or your insurance provider or intermediary if you have an individual policy.

Sample Summary of Coverage Details

Mr./Ms.	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Card No.:	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Alternative Medicine	Covered
Alternative Medicine Access	02 Reimbursement & Free Access
Alternative Medicine Copayment	10%
Alternative Medicine Reimbursement Copayment	0
Annual benefit Limit	500000
Approvals Classification	Standard
Check-up Plan	Not Covered
Chronic Condition Waiting Period (Months)	0 Month(s)
DHA Member Registration ID	XXXXXXXXXXXXXXXXXXX
Dental Access	02 Reimbursement & Free Access
Dental Copayment	20%
Dental Coverage	Covered
Dental Limit	3500
HAAD/DHA Approval Number	DHA-MN54003B
Inpatient Copay	0%
Laboratory Services Copayment	10%
Maternity IP Plan	Covered
Normal Delivery Limit	20000
Optical Access	01 Reimbursement

Your Benefits at a Glance

Your Coverage Summary provides an overview of your health insurance benefits. Understanding the key sections will help you make the most of your coverage.

1. **Plan Name:** The health insurance plan that applies to you.
2. **Geographical Scope:** The countries or regions where your policy provides coverage and where you can access eligible medical treatment.
3. **Annual Benefit Limit:** The maximum amount payable under your policy during a policy year.
4. **Inpatient Benefits:** Coverage for services received while admitted to a hospital, including hospitalization, surgery, and day-care treatments.
5. **Outpatient Benefits:** Coverage for services that do not require hospital admission, such as consultations, diagnostic tests, and specialist visits.
6. **Pharmacy Benefits:** Coverage for prescribed medications, including any applicable limits or member cost sharing.
7. **Maternity Benefits:** Coverage, limits, and conditions for maternity-related services, where included under your plan.
8. **Additional Benefits:** Dental, optical, wellness, and other benefits that may be included in your plan. These may have their own coverage limits.
9. **Member Cost Sharing:** Any applicable co-payments, deductibles, co-insurance, or other amounts payable by you, as outlined in your coverage
10. **Special Conditions:** Any pre-approval requirements, waiting periods, or other coverage conditions that may apply.

If you would like to verify your coverage or need clarification on any benefit, limit, or condition, please contact us before receiving treatment.

We will be happy to help you understand your benefits and confirm whether a treatment or service is covered, subject to the terms, conditions, limitations, and exclusions of your policy.

Common Insurance Terms

Here you will find a list of common insurance terms that will help you better understand your policy.

- **Annual benefit limit:** Maximum amount that your insurer pays for treatments.
- **Area / Territory of Coverage:** refers to the geographical region where the benefits of an insurance policy apply
- **Co-insurance:** A percentage of the eligible medical expenses that you are required to pay, with the remaining amount covered by the insurer, subject to the terms and conditions of your policy.
- **Covered Services:** Medical services that are eligible for reimbursement or payment under your health insurance policy, subject to the terms, conditions, and benefit limits.
- **Uncovered Services:** Medical services that are not eligible for reimbursement or payment under your health insurance policy.
- **Day Case Treatment:** Medical treatment, surgery, or a procedure that requires admission to a hospital or medical facility but does not require an overnight stay. The patient is admitted, receives treatment, and is discharged on the same day.
- **Deductible:** A fixed amount that you must pay towards eligible medical expenses before your insurance coverage applies, where applicable.
- **Direct Billing:** the insurer pays the hospital or clinic directly for your treatment, so you don't need to file a reimbursement claim. You only pay your co-insurance, which is the percentage of the medical bill that is not covered by your insurance.
- **Insurer:** the insurance company that provides the insurance coverage and pays eligible claims according to the policy terms.

- **Insured:** the policy holder or members covered by the insurance policy.
- **Network Provider:** The group of healthcare providers (hospitals, clinics, etc) covered by your insurance through MedNet. Different providers may require you to pay different amounts of co-insurance.
- **Out-patient benefit:** Medical services that don't require hospitalization or specialized medical attention.
- **Pharmaceuticals:** Medicines that are approved for use in the country where they are prescribed and can only be obtained with a prescription from a qualified medical practitioner. These drugs are regulated and used to treat, manage, or prevent health conditions under medical supervision.
- **Policy Wording:** A document that explains your benefits and coverage, including what is and isn't covered.
- **Pre-authorization:** Approval from the INSURER required before treatment to confirm it is covered under your plan and within agreed charges.
- **Reimbursement Claim:** Eligible medical expenses incurred by you that are reimbursed if covered under your plan.
- **Underwriting:** insurance company's review of your medical records to determine your eligibility for coverage, the cost of the policy, and any conditions that may apply.
- **Usual and Customary Rate (UCR) or Reasonable and Customary Rate (RCR):** The maximum amount considered reasonable and payable for a medical service, based on the typical charges for the same or similar treatment by healthcare providers within the UAE. If a healthcare provider charges more than the applicable UCR/RCR, you may be responsible for paying any amount that exceeds this limit.
- **Waiting period:** is the time you have to wait after obtaining health insurance before some benefits or treatments are covered.

mednet

How to Use Your Insurance for Medical Treatment

Now that you are familiar with your benefits, we will explain how to access medical services using your insurance card.

How and Where to Get Care

If you are feeling unwell and need to consult a doctor, you may review the healthcare options available to you.

Treatment at In-Network Providers

With an in-network provider, the provider will bill your insurer directly. You only need to pay any required co-payment or co-insurance.

No claim submission is usually required.

Direct Billing Benefits

Direct billing is convenient. You only pay any deductible or co-insurance.

Simple Steps:

- Show your digital insurance card at the provider's reception.
- Follow the provider's instructions.
- You will be informed if the treatment requires prior approval from your insurer, which is administered by MedNet, before it can proceed.
- Check the approval status on the MyHealthPass app or Member Portal.
- The provider will submit the claim for direct billing in accordance with your insurer's requirements, where applicable.

Treatment at In-Network Providers

How to Use Your Card Outside the UAE Within Network (MedNet Markets)

This applies when receiving treatment in Oman, Bahrain, Kuwait, Qatar, Egypt, Jordan, and the Kurdistan Region.

Simple Steps:

- Present your MedNet e-card via the MyHealthPass app or Member Portal at the time of your visit.
- Receive treatment in accordance with your policy coverage, terms, conditions, and benefit limits.
- Pay any applicable co-payment, co-insurance, deductible, or non-covered charges.
- You may be asked to sign claim- or treatment-related documents, depending on the provider.
- Allow time for eligibility and coverage verification administered by MedNet.
- The provider will submit the claim for direct billing in accordance with your insurer's requirements.

Finding a Network Provider

If you need medical treatment, you can find in-network providers, including clinics, hospitals, and pharmacies, through the Member Portal or the MyHealthPass app.

- Go to the "Find a Provider" section to search for covered providers by location, provider type or facility name.
- Using in-network providers helps you access appropriate care while minimizing out-of-pocket costs.

Treatment at Out-of-Network Providers

With an out-of-network provider, you will pay for the treatment yourself and then submit a claim to be reimbursed. The reimbursement amount depends on your plan and may be reduced by any applicable coinsurance or coverage limits.

When You Can Request Reimbursement

If you receive treatment outside your insurance network, you may request reimbursement for eligible expenses, provided the services are covered under your plan and reimbursement is included in your policy.

Submitting a claim through your MyHealthPass mobile app or Member Portal is so convenient and easy.

Upload the required documents.

Submit your claim.

Please submit a completed medical claim form along with supporting documents such as medical reports, prescriptions, test results, invoices, receipts, and a doctor's diagnosis. Please also include your personal bank account details (IBAN). Additional documents may be requested depending on the treatment.

- All invoices must include a clear breakdown of charges and proof of payment. Missing documents may delay processing or result in claim rejection.
- If a co-pay or patient share applies, it will be deducted from the reimbursed amount according to your policy and schedule of benefits.

How Long Do Claims Take?

Reimbursement claims are processed after all required documents have been received. Processing timelines may vary depending on your insurer and policy.

Please note that payments are facilitated and funded by your insurer in accordance with your policy terms and conditions. Delays may occur due to bank screening and security checks.

Incomplete Reimbursement Claims

If additional information or documents are required, MedNet will notify you on behalf of your insurer. Please provide the requested information or documents promptly to help avoid delays in processing your claim

Submission Timeframe

We recommend submitting your reimbursement claim shortly after receiving treatment to help avoid delays and ensure it is submitted within the timeframe specified in your insurance policy. As submission deadlines vary by insurer, please refer to your policy terms or contact your insurer. If you are covered under a group policy, please contact your HR department to confirm the applicable submission time frame.

When is Pre-Approval Required?

Some services require pre-approval to ensure coverage and facilitate direct billing:

- Hospital admissions and day-case procedures

  Medical and surgical admissions, including procedures requiring a hospital stay of more than six hours.
- Selected outpatient procedures and diagnostic tests

  MRI, CT scans, endoscopies, biopsies, FNAC, IVP, MCU, myelogram, nuclear studies, nerve conduction studies, cardiac stress tests, echocardiography, vitamin D tests, mammograms, and allergy tests.
- Limit-based benefits

  Physiotherapy, dental services, alternative medicine services, and vaccinations.
- Pharmacy (PBM) approvals

  Medications exceeding approved duration or prescription value, as defined in your policy terms.

Who Manages Pre-Approval Requests?

MedNet acts as the administrative service provider for your health insurance plan and receives pre-approval requests directly from the healthcare provider (clinic or hospital). These requests include relevant medical reports and supporting clinical documentation.

MedNet reviews and processes each request on behalf of the insurer, in accordance with your policy coverage, Table of Benefits, and applicable policy terms and conditions. The final approval decision is made by the insurer and is communicated to the healthcare provider through MedNet.

How Will I Know If It Has Been Submitted?

You will receive a notification and an update on the MyHealthPass mobile application once the provider submits the request.

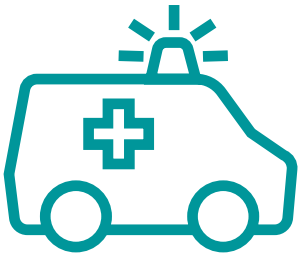
Delays in Approval

Approval may be delayed due to:

1. Request not yet submitted by the provider
2. Missing medical documents or clinical information
3. Additional clarification required from the provider

If your approval is delayed, you are advised to contact your healthcare provider or MedNet Customer Service for assistance.


mednet
Medical Care
Emergency or
Non-Emergency?



What to Do in an Emergency

An emergency medical condition is a sudden illness, injury, or medical situation that requires immediate treatment to prevent serious harm to your health or life.

In the event of a medical emergency, your health and well-being are the highest priority. Please seek immediate medical attention without delay.

Emergency Care in the UAE

Prior approval is not required for emergency treatment.

Network providers will coordinate with MedNet to complete eligibility and coverage verification on behalf of your insurer.

For inpatient admissions, providers will notify MedNet within 24 hours before discharge or within 48 hours of admission, whichever is earlier, to support coordination of services in line with your policy benefits.

Emergency Care Outside the UAE

(Within Policy Geographical Scope)

Providers may contact MedNet to support coordination of care, eligibility verification, and, where possible, facilitate direct billing or a guarantee of payment on behalf of your insurer.

If direct billing or a guarantee of payment cannot be arranged, you may be required to settle the medical expenses directly and submit a reimbursement claim. Reimbursement will be subject to your policy terms and conditions and insurer approval.

Non Emergency Care

For non-emergency or elective treatment, you are advised to use a network provider and obtain any required pre-approvals before receiving treatment to avoid delays or non-covered expenses.

Exclusions

An exclusion refers to any treatment, service, medical condition, medication, or expense that is not covered under your health insurance policy. Any costs related to excluded items are the responsibility of the member and will not be reimbursed or paid by the insurer.

Coverage is subject to the applicable health insurance regulations issued by the Dubai Health Authority (DHA) and/or the Department of Health – Abu Dhabi (DoH), where applicable, in addition to the terms and conditions of your policy. For the latest regulatory information and applicable requirements, please refer to the official DHA and DoH websites.

As coverage, benefits, and exclusions may vary depending on your specific policy, please contact your insurer or HR department for clarification regarding your plan coverage and any applicable exclusions.

Some Common Exclusions

The following are examples of commonly excluded services. This list is not exhaustive, and coverage may vary depending on your policy terms and conditions.

- **Services requiring pre-approval that were not approved**
  Any treatment, procedure, or medication that requires pre-approval but was received without obtaining approval from the insurer (processed through MedNet), where applicable under the policy terms.
- **Pre-existing or undisclosed conditions (Applicable to individual policies only)**
  Conditions that are not covered under your policy terms, including undeclared pre-existing conditions, where applicable.
- **Cosmetic and aesthetic treatments**
  Procedures that are not medically necessary, including cosmetic surgery and aesthetic treatments.
- **Fertility and reproductive services**
  Assisted reproduction, infertility treatments, and related services, unless specifically covered under your policy.
- **Weight management treatments**
  Including bariatric surgery and related procedures, unless medically indicated and pre-approved in accordance with your policy terms.
- **Routine dental care**
  Dental treatments not covered under your dental benefit, unless specifically included in your policy.
- **Vision correction procedures**
  Such as LASIK or refractive surgery, unless explicitly covered under your policy.

- **Experimental or investigational treatments**
  Treatments that are not accepted as standard medical practice or are considered investigational.
- **Medications outside policy limits**
  Including medications requiring pre-approval that were not approved, or medications exceeding the applicable benefit limits or policy conditions.
- **Non-covered pharmacy items**
  Over-the-counter medicines, supplements, and vitamins, unless prescribed and covered under the policy terms.
- **Non-emergency elective treatment without approval (where required)**
  Services that require pre-approval but were obtained without prior authorization from the insurer, coordinated through MedNet.
- **Out-of-scope treatment**
  Services received outside the geographical scope of your policy, except where emergency coverage applies in accordance with your policy terms.
- **Non-medical or administrative charges**
  Administrative fees, missed appointment charges, medical reports, personal comfort items, and other non-medical expenses.
- **Hazardous activities or unlawful acts**
  Injuries or illnesses arising from activities or circumstances excluded under your policy terms or applicable regulations.

More Ways to Support Your Health

Depending on your membership plan and policy, you may have access to a range of additional services designed to support your health and wellbeing, including:

Telehealth: Consult a licensed doctor online anytime, from wherever you are.

Member Discounts: Enjoy exclusive savings on selected healthcare services through our network providers.

Mental Wellness: Access Wysa, your digital wellbeing companion, for self-care tools and emotional support.

Chronic Refill: Arrange recurring refills with convenient home delivery for your long-term medications.

Pharmacy Delivery: Have your prescribed medications delivered to your home, workplace, or preferred location.

Health Newsletters: Receive monthly wellness tips, health updates, and information on your member benefits.

Always here to support you

We hope this welcome guide has helped you get to know your MedNet services a little better.

If you ever need a reminder or want to check how a service works, you can come back to this guide anytime.

If you have any questions, we're always here for you – just reach out through any of the channels below.

We're happy to help!

My Health Pass by MedNet

Download the app here

Customer Service

Inside the UAE 800 4882

Outside the UAE +971 4390 0749

Email customerservice@mednet.com

Website www.mednet.com

Guarantee of Payment (GOP) requests for international treatment (outside the UAE)

Email mcu@mednet.com

To help us handle your enquiry efficiently, please include

- Your full name
- Your Medical Insurance Card number or Emirates ID
- Your contact details
- A brief description of your enquiry or request
- Any supporting documents or relevant correspondence

Disclaimer

This material is issued by MedNet Global Healthcare Solutions L.L.C. situated in the UAE, a licensed Third-Party Administrator (TPA) incorporated in the United Arab Emirates ('UAE') under Commercial License number CN- 2149549 and regulated by the Dubai Health Authority, Department of Health and the Central Bank of the UAE.

MedNet Global Healthcare Solutions LLC ("MedNet") provides services only as a third-party administrator (TPA) and as a TPA, does not underwrite or issue insurance policies, and does not assume insurance risk. All services are rendered in accordance with agreements between MedNet and insurers, employers, or plan sponsors. Consequently, MedNet does not fund or pay claims and is not liable for any claim payment or settlement. Responsibility for all claim payments remains solely with the primary insurance company that issued the insurance policy.

This material is intended for general informational purposes only and does not constitute insurance advice, policy guarantees, or a binding offer/contract. All insurance products and services referenced are subject to the terms, conditions, and exclusions of the respective insurance policies issued by the licensed insurance company and may vary by jurisdiction.

This material is not intended for distribution in jurisdictions where such distribution would be contrary to local laws or regulations. Unauthorized reproduction or sharing of this content is prohibited without prior written consent from MedNet. All content is current as of the date of publication and subject to change without notice. While we strive for accuracy, no warranties or representations are made regarding the completeness, reliability, or accuracy of the information provided.

For details specific to your insurance coverage or claims, please consult directly with your insurer or broker, or contact us for clarification within the scope of our licensed administrative role.