Table of Benefits

The table(s) below lists all of the benefits covered under the quotation. Treatment Guarantee (pre-authorisation) is required for all benefits indicated with a 1 or 2 in the following table(s) and may be required for other benefits. Please refer to Notes section for more information. All benefit and deductible amounts are per person, per Insurance Year, unless otherwise indicated.

Overall maximum plan benefit $	$13,400,000

Core Plan	S&P GLOBAL QATAR
Maximum plan benefit	Included within overall maximum plan limit
In-patient benefits[1]	
Hospital accommodation[1]	Private room
Intensive care[1]	Full refund
Prescribed drugs and materials[1] (in-patient and day-care treatment only)	Full refund
Surgical fees, including anaesthesia and theatre charges[1]	Full refund
Physician and therapist fees[1] (in-patient and day-care treatment only)	Full refund
Surgical appliances and materials[1]	Full refund
Diagnostic tests[1] (in-patient and day-care treatment only)	Full refund
Organ transplant[1] (in-patient treatment only)	Full refund
Psychiatry and psychotherapy[1] (in-patient and day-care treatment only)	Full refund
Accommodation costs for one parent staying in hospital with an insured child under 18[1]	Full refund
Accommodation costs for one person accompanying an insured person in cases of medical necessity[1]	$136 per night
Reconstructive surgery[1] (to restore natural function or appearance after a disfiguring accident or surgery for cancer) (where treatment for the accident or initial surgery is covered by this policy)	Full refund
CT and MRI scans[1] (in-patient and day-care treatment only)	Full refund
PET and CT-PET scans[1] (in-patient and day-care treatment only)	Full refund
Emergency in-patient dental treatment	Full refund
Other benefits	
Day-care treatment[2]	Full refund
Kidney dialysis[2] (in-patient, day-care and out-patient treatment)	Full refund
Out-patient surgery[2]	Full refund
Nursing at home or in a convalescent home[2] (immediately after or instead of hospitalisation)	$200 per day max. 30 days
Rehabilitation treatment[2] (in-patient, day-care and out-patient treatment; must commence within 14 days of discharge after the acute medical and/or surgical treatment ceases) (covered only if you've received in-patient treatment for three or more consecutive days/nights for the same medical condition)	Max. 60 days per discharge

Local ambulance	Full refund
Local air ambulance	$10,000
Post-hospitalisation treatment (covered when it is needed in the 90 days following discharge from in-patient or day-care treatment for the same acute medical condition)	Full refund
Emergency treatment outside area of cover (for trips of a maximum period of six weeks)	Full refund max. 28 days
Medical evacuation[2] (in the event of emergency treatment) · Where necessary treatment is not available locally, we will evacuate the insured person to the nearest appropriate medical centre[2] · Where ongoing treatment is required, we will cover hotel accommodation costs[2] · Evacuation in the event of unavailability of adequately screened blood[2] · If medical necessity prevents an immediate return trip following discharge from an in-patient episode of care, we will cover hotel accommodation costs[2]	Full refund max. 14 days
Expenses for one person accompanying an evacuated person[2]	Full refund
Travel costs of insured family members in the event of an evacuation[2]	Full refund
Repatriation of mortal remains or burial expenses[2]	Full refund
Travel costs of insured members to be with a close relative who is at peril of death or who has died (five round trips per insured member per Insurance Year)	$1,600 per trip
Oncology[2] (in-patient, day-care and out-patient treatment) • Purchase of a wig, prosthetic bra or other external prosthetic device for cosmetic purposes	Full refund $675
Preventative surgery[2] (in-patient, day-care and out-patient treatment)	Full refund
Newborn care[2] (in-patient and out-patient treatment)	Full refund
In-patient cash benefit (per night) (where treatment has been received free of charge)	$150 max. 20 nights
Congenital conditions[2] (in-patient and day-care treatment only)	Full refund
Out-patient dental treatment (required as follow-up to an in-patient stay for accidental damage to natural teeth) (covered when required in the 90 days following discharge from in-patient treatment)	Full refund
Emergency out-patient dental treatment	Full refund
Palliative care[2] (in-patient, day-care and out-patient treatment)	$41,000
Long term care[2] (in-patient, day-care and out-patient treatment)	Max. 90 days per lifetime
HIV/AIDs treatment[2] (in-patient, day-care and out-patient treatment)	$40,850
Laser eye surgery (in case of emergency only)	Full refund
Prescribed glasses and contact lenses including eye examination (in case of emergency only)	Full refund

Prescribed hearing aids (in case of emergency only)	Full refund
Bariatric surgery[2] 24 month waiting period applies	Full refund
Additional Core Plan Services	
Employee Assistance Programme Offers access to a range of 24/7 multilingual support services as follows: · Confidential professional counselling (in-person, phone, video and chat) · Legal and financial support services · Critical incident support · Wellness website access	Services available
Travel Security Services Offers 24/7 access to personal security information and advice for all your travel safety queries. This includes: · Emergency Security Assistance Hotline (not a free phone number) · Country intelligence and security advice · Daily security news updates and travel safety alerts	Services available
MyHealth Digital Services · Manage your cover online with our app or portal anytime, anywhere. · Submit and track progress of claims. · Access your policy documents, health services, payment details and more.	Services available
Olive Our Health & Wellness support program includes, for example: · HealthSteps fitness app · Access to wellness resources	Services available
Second Medical Opinion Service Offers access to expert help on the best treatment options available if you have been diagnosed with a serious illness or had surgery recommended	Services available

Out-Patient Plan	**S&P GLOBAL QATAR**
Maximum plan benefit	Included within overall maximum plan limit
Pre-hospitalisation tests (covered when they are needed in the 72 hours before in-patient or day-care treatment)	Full refund
Video consultation services	Full refund
Medical practitioner fees	Full refund
Prescribed drugs and dressings	Full refund
Specialist fees	Full refund
Diagnostic tests	Full refund
MRI scans	Full refund
Emergency out-patient treatment	Full refund
PET and CT-PET scans[2]	Full refund
CT scans	Full refund
Post-hospitalisation physiotherapy (covered when required in the 90 days following in-patient or day-care discharge)	Full refund
Prescribed physiotherapy (referral from doctor required) (initially limited to 12 sessions per condition)	50 sessions
Chiropractic treatment, osteopathy, and podiatry (max. 12 sessions per condition for chiropractic treatment and max. 12 sessions per condition for osteopathic treatment, subject to the benefit limit)	30 sessions
Homeopathy, Chinese herbal medicine, Tui na, cupping, bone setting, acupuncture and ayurvedic treatment	

Psychiatry and psychotherapy (referral from doctor required for psychotherapy and initially limited to 10 sessions per condition)	Full refund
Prescribed medical aids	$11,200
Dietician fees	3 visits

Wellness Plan	S&P GLOBAL QATAR Wellness
Vaccinations (up to and including 18 years of age)	Full refund
Vaccinations (from age 19 years and older)	$1,000
Health and wellbeing checks including screening for the early detection of illness or disease	$2,000
Cancer screening	
Annual eye examination	Full refund
Well child test (for children up to the age of six years)	Full refund

Dental Plan	S&P GLOBAL Dental
Maximum plan benefit	$4,100
Dental treatment	Full refund
Dental surgery	Full refund
Periodontics	Full refund
Dental prostheses	50% refund
Orthodontic treatment	50% refund
Dental implants	50% refund

Maternity Plan	S&P GLOBAL QATAR Maternity
Routine maternity[2] (in-patient and out-patient treatment)	Full refund
Complications of pregnancy and childbirth - In the event of emergency treatment - In the event of non emergency treatment[2]	Full refund Full refund Full refund
Elective circumcision for newborn males	$500

Optical Plan	S&P GLOBAL Optical
Prescribed glasses and contact lenses	75% refund Up to $425

REPATRIATION PLAN	Summit 5000 Repatriation Plan

Medical repatriation[2] · Where the necessary treatment is not available locally, you can choose to be medically repatriated to your home country instead of to the nearest appropriate medical centre. This benefit only applies when your home country is within your area of cover[2] · Where ongoing treatment is required, we will cover hotel accommodation costs[2] · Repatriation in the event of unavailability of adequately screened blood[2]	Full refund
· If medical necessity prevents an immediate return trip following discharge from an in-patient episode of care, we will cover hotel accommodation costs[2]	max. 14 days
Expenses for one person accompanying a repatriated person[2]	$4,050
Travel costs of insured family members in the event of a repatriation[2]	$2,700 per event

NOTES

Hospital network - Comprehensive

The name of the provider network applicable to your cover is indicated on your personal Access Card and a list of the medical providers included in your network was issued with your membership pack.

Your provider network includes a large number of clinics/hospitals and pharmacies that have contractual arrangements in place with us. Upon presentation of your Access Card each of these clinics/hospitals and pharmacies will provide their services and products without seeking immediate payment from you, unless the prescribed treatment is specifically excluded under your policy.

Please note that under some benefits, cover may be available on a reimbursement basis only, i.e. you will have to pay for eligible treatments and then complete and submit a Claim Form. For further details please refer to "Getting treatment" section of your Employee Benefit Guide.

Pre-authorization
For certain benefits listed in your Table of Benefits, you are required to submit a completed Pre-authorization Form in advance of receiving your treatment. Following approval by us, cover can then be guaranteed. In the Table of Benefits, benefits which require pre-approval through submission of a Pre-authorization Form are indicated by either a **1** or a **2**.

If you choose to be treated within your provider network, then your medical provider will automatically deal with us directly for Pre-authorization, where necessary.

However, where you choose to be treated outside of the provider network, you will need to ensure that you contact us for the necessary Pre-authorization. Full details of our Pre-authorization process are provided in the Employee Benefit Guide issued at policy inception. Please note that:

- If Pre-authorization is not obtained for the benefits listed with a 1, we reserve the right to decline a claim. If the respective treatment is subsequently proven to be medically necessary, we will pay only **80%** of the eligible benefits.
- If Pre-authorization is not obtained for the benefits listed with a 2, we reserve the right to decline a claim. If the respective treatment is subsequently proven to be medically necessary, we will pay only **50%** of the eligible benefits.
- In the case of an emergency, you don’t need to submit the Pre-authorization Form in advance but we should be informed within 48 hours of the event to ensure that no Pre-authorization penalty apply to your claim.

For further details please refer to our Benefit Guide, or simply contact our Helpline.

Chronic conditions
Chronic conditions are covered within the limits of the selected plan during the Insurance Year.

Pre-existing conditions

Pre-existing conditions are covered within the limits of the selected plan during the Insurance Year.

Benefit limits
There are two kinds of benefit limits shown in the Table of Benefits. The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan. Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis, such as per trip, per visit or per pregnancy. Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

Policy terms and conditions
Your Table of Benefits provides an outline of the cover we provide under each plan. Cover is subject to our policy terms and conditions, as detailed in our Employee Benefit Guide which is issued to members upon policy inception.

Policy endorsement(s)
If there are any policy terms and conditions unique to your policy they will be listed below. Please read carefully in conjunction with our Employee Benefit Guide.

Certain services that may be included in your plan are provided by third party providers, such as the Employee Assistance Programme, Travel Security services, fitness app, Second Medical Opinion and tele-medicine services. If included in your plan, these services will show in this Table of Benefits. These services are made available to you subject to your acceptance of the terms and conditions of your policy and the terms and conditions of the third parties. These services may be subject to geographical restrictions. The fitness app does not provide medical or health advice and the wellness resources contained within Olive are for informational purposes only. The fitness app and the wellness resources contained within Olive shouldn’t be regarded as a substitute for professional advice (medical, physical or psychological). They are also not a substitute for the diagnosis, treatment, assessment or care that you may need from your own doctor. You understand and agree that the insurer, its reinsurers and administrators are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of any of these third party services.

The following exclusions will not apply:

Obesity Treatment - Investigations into and treatment for obesity including bariatric surgery, diet pills or supplements, health club memberships, diet programs or residential eating disorder programs.

The following additional definitions will apply:

Bariatric surgery - refers to surgical procedures aimed to achieve weight loss, out of medical necessity. The surgical procedures we cover are: gastric bypass surgery, sleeve gastrectomy surgery, biliopancreatic diversion (with or without duodenal switch) and laparoscopic adjustable silicone gastric banding surgery. It also refers to all pre and post-surgery assessments, consultations and any complications thereafter, up to the benefit limit. Cover is only provided where all the following conditions are met:
You have a BMI of 40 or above, or a
a) BMI between 35 and 40 in addition to two of the following significant diagnoses that could be improved with weight loss: Hypertension, Type 2 Diabetes Mellitus, Hypercholesterolemia, Ischemic Heart disease.
b) You have tried all appropriate non-surgical measures but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least one year. All efforts and compliance with healthy eating and regular exercise need to be proven to Allianz Care.
c) You have received, or will be receiving intensive management in a specialist obesity service. We have the right to decide if an obesity clinic/bariatric surgeon is operating as a reasonable specialist obesity service.
d) You are deemed fit for anesthesia and surgery.

e) You commit to the need for long-term follow up and supervision.
Our medical director reserves the right to decline cover for Bariatric surgery if considered as non-medically necessary."

Local air ambulance - refers to transport by local air ambulance (typically a medically-equipped and staffed helicopter or plane) when related to eligible in-patient treatment or day-care treatment, either: from the location of an accident to hospital, or for a transfer from one hospital to another, when it is appropriate for this method of transfer to be used to transport you over short journeys of up to 160 km.