Allianz Care

Employee Benefit Guide

Summit – International Healthcare Plans for Qatar
Valid from 1st July 2022

Welcome

You and your family can depend on Allianz Care, as your international health insurer, to give you access to the best care possible.

This guide has two parts: "How to use your cover" is a summary of all important information you are likely to use on a regular basis. "Terms and conditions of your cover" explains your cover in more detail.

To make the most of your international healthcare plan, please read this guide together with your Insurance Certificate, Access Card and Table of Benefits.

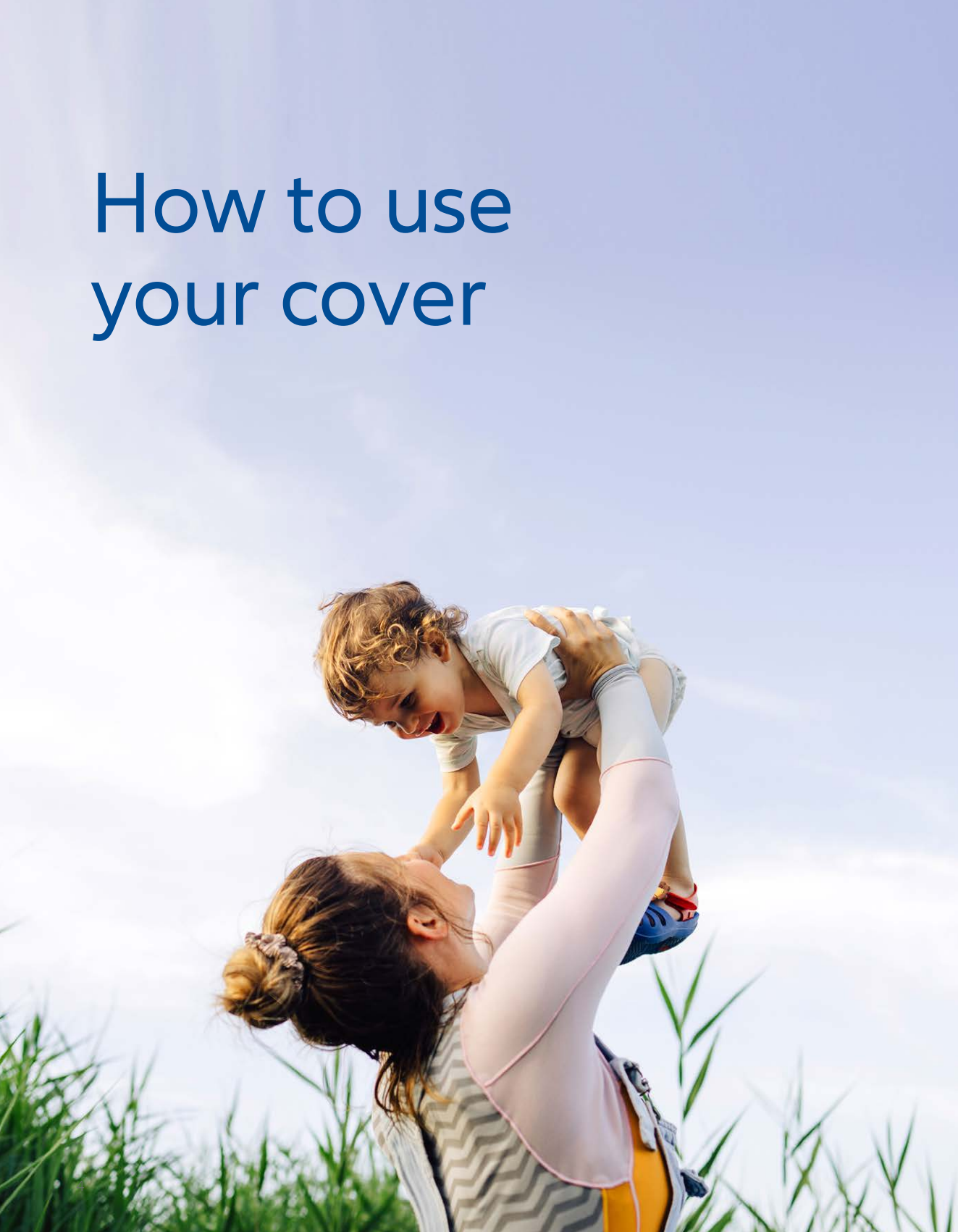
How to use your cover

Terms and conditions of your cover

AWP Health & Life SA. QFC Branch address: Office 604-C, 6th floor, Jaidah Square Building, 63 Airport Road, Zone 27, Umm Ghuwailina, P.O. Box 55171, Doha, Qatar. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA. Phone: +974 4031 8444. Fax: +974 4031 8484. Website: www.allianzcare.com

Authorised by the Qatar Financial Centre Regulatory Authority. AWP Health & Life SA is incorporated in France.

How to use your cover



Support services

We believe in providing you with the top-quality service that you deserve. In the following pages we describe the full range of services we offer. Read on to discover what is available to you, from our MyHealth Digital Services to the Employee Assistance Programme.

Talk to us, we love to help!

Our multilingual Helpline is available 24 hours a day, 7 days a week, to handle any questions about your policy or if you need assistance in an emergency.

Helpline

8000 155 (calling toll-free within Qatar)
+974 403 18444 (calling from within or outside of Qatar)

Email: **client.services@allianzworldwidecare.com**

Fax: **+974 403 18484**

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

MyHealth Digital Services

Through MyHealth, available as a mobile app and online portal, you will have easy and convenient access to your cover, no matter where you are or what device you are using.

MyHealth app and online portal features

My policy
Access your policy documents and access card on the go.

My claims
Submit your claims in 3 simple steps and view your claims history.

My contacts
Access our 24/7 multilingual Helpline. Live chat is also available (in English and on the online portal only).

Symptom checker
Get a quick and easy assessment of your symptoms.

Find a hospital
Locate medical providers nearby.

Pharmacy aid
Look up the local equivalent names of branded drugs.

Medical term translator
Translate names of common ailments into 17 languages.

Emergency contact
Access local emergency numbers worldwide.

Additional useful features

- Update your details online: email, phone number, password, address (if it's the same country as the previous address), marketing preferences, etc.
- View the remaining balance of each benefit which is in your Table of Benefits
- Pay your premium online and view payments received
- Add or change your credit card details (if you are responsible for paying your own premium, rather than your employer)

All personal data within MyHealth Digital Services is encrypted for data protection.

Getting started:

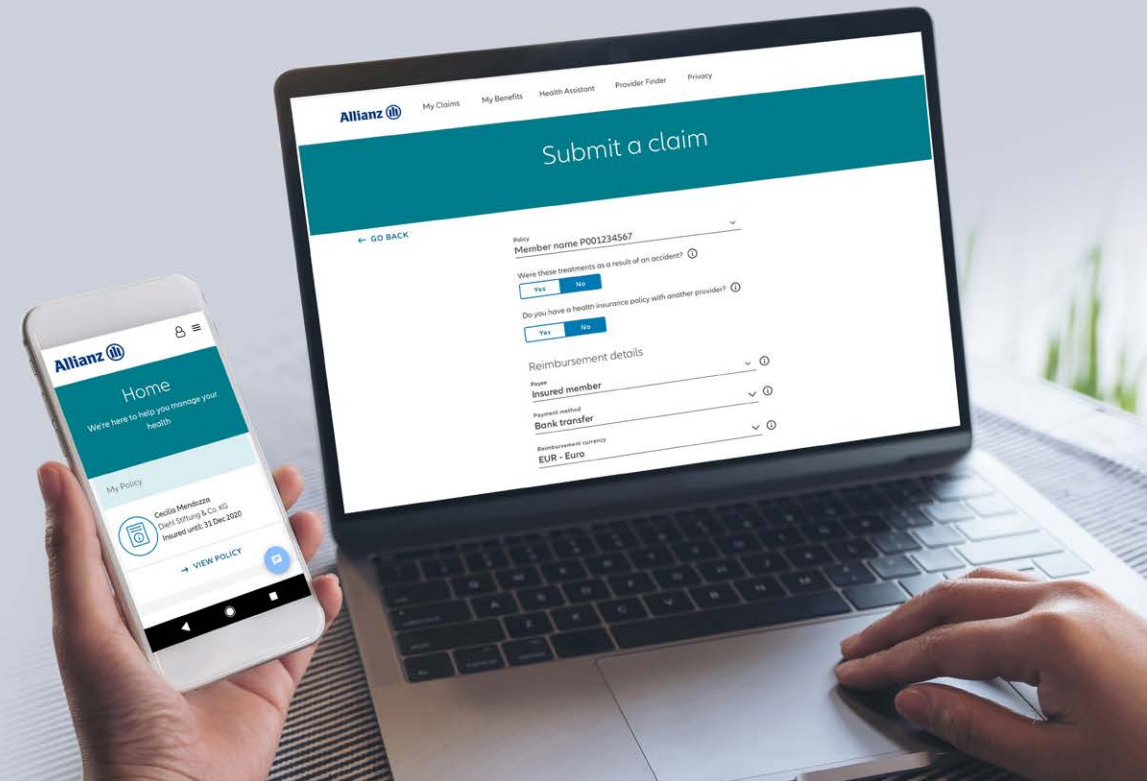
1. Login to MyHealth online portal to register. Go to **https://my.allianzcare.com/myhealth**, click on "REGISTER HERE" near the bottom of the page and follow the on-screen instructions. Be ready to provide your policy number, which you can find in your Insurance Certificate.

2. As an alternative, you can register via our MyHealth App. To download it, search for "Allianz MyHealth" on the Apple App Store or Android's Google Play service.

   Download on the App Store GET IT ON Google Play

3. Once set up, you can use the email (username) and password you provided during registration to login to MyHealth online portal or app. The same login details are used for both and in the future, if you change login details for one, it will automatically apply to the other. You don't need to change them in both places. We also offer a biometric login option for the app, for example Touch ID or Face ID, where supported by your device.

For more information, please visit **www.allianzcare.com/en/myhealth.html**



Web-based services

On **www.allianzcare.com/members** you can:

- Search for medical providers (you are not restricted to using the providers listed in our directory)
- Download forms
- Access our Health Guides
- Access our "My expat life" hub – from planning to move, to settling down in your new country, you'll find everything you need to know about moving overseas

Second Medical Opinion**

As your health partner, we aim to provide you with peace of mind. Have you been diagnosed with a serious illness or had surgery recommended? Do you want expert help on the best treatment options available and where to get the most appropriate treatment? As part of your cover you have access to our Second Medical Opinion service.

When you access this service, we assign to you a dedicated case manager, i.e. a healthcare professional from our own Medical Team to guide and assist you. Your case manager will ask you to provide all the necessary information about your medical case: then he/she will help you find a hospital, doctor or specialist for the Second Medical Opinion and provide the opinion to you.

To access our service, simply call our 24/7 Helpline on:

+ 353 1 630 1301

...and ask for the Second Medical Opinion service. You will need to state your policy number for identification.

Olive - Allianz Care's Health and Wellness support program

Your first steps towards a healthier life.

In today's increasingly busy and ever-changing world we recognise the importance of staying healthy and we firmly believe that prevention is better than cure. Olive**, our proactive care engine, is designed to motivate and guide you towards a healthier life. It includes the Health and Wellness hub and our HealthSteps app.

1. Health and Wellness hub

Our Health & Wellness Hub, accessible via our MyHealth Digital Services (mobile app and portal), offers you a range of services gathered in one convenient place to support you on your journey to a long, happy and healthy life.

On the Hub you will have access to:

- Tips and articles on topics such as sleep, fitness, nutrition and emotional wellbeing.
- Online health assessments**.
- Our BMI calculator.
- Our monthly live health and wellness webinars, with Q&A session, delivered by specialists.

2. HealthSteps app**

Did you know that by maintaining a healthy lifestyle, you may reduce the risk of developing medical conditions? The Allianz HealthSteps app was designed to give personalised guidance and help you reaching your health and fitness goals. By connecting to smart phones, wearables devices and other apps, HealthSteps monitors the number of steps taken, calories burned, sleep schedule and more.

HealthSteps features:

Plan
Choose a health goal and use the action plans to adopt and maintain good health habits:

- Lose weight
- Improve posture
- Sleep better
- Eat healthy
- Get moving and energised
- Stay healthy
- Reduce stress
- Lower blood pressure

Challenges
Join monthly challenges and get encouragement from other HealthSteps users by sharing your performance and competing against each other on group challenges. These challenges are based on steps, calories and distance.

Progress
Connect with popular health and activity trackers and monitor your progress against goals you set for yourself.

Library
Access articles and get tips and advice on how to live and maintain a healthy life.

Download the "Allianz HealthSteps" app from App Store or Google Play.

Download on the App Store GET IT ON Google Play

Video consultation services via Telehealth Hub**

If your plan includes the 'Video consultation services' benefit you have direct access to online doctor appointments (video consultation services) where a provider is available in your geographical location.

With the Telehealth Hub, you can save time by seeing a doctor via video from the comfort of your own home or office. Offering a secure and confidential service, our telehealth network of doctors can provide medical advice, recommend treatments and offer prescriptions for non-emergency concerns.

The service is accessible via MyHealth portal or directly via our TeleHealth platform at:

www.allianzcare.com/telehealthhub

An appointment can be made to speak to a medical practitioner in English, subject to availability. Some third party providers may offer the service in additional languages.

Depending on your geographical location, local country regulations and insurance plan coverage, the teleconsultation service may also offer prescriptions.

In countries where a teleconsultation service is not yet available, you can always call our 24/7 medical advice helpline – this service is offered in English, German, French and Italian. The phone number is available on TeleHealth Hub.

Employee Assistance Programme (EAP)**

When challenging situations arise in life or at work, our Employee Assistance Programme provides you and your dependants with immediate and confidential support. EAP, where provided, is shown in your Table of Benefits.

This professional service is available 24/7 and offers multilingual support on a wide range of challenges, including:

- Work/Life balance
- Family/Parenting
- Relationships
- Stress, depression, anxiety
- Workplace challenges
- Cross-cultural transition
- Cultural shock
- Coping with isolation and loneliness
- Addiction concerns

Support services include:

Confidential professional counselling
Receive 24/7 support with a clinical counsellor through live online chat, face to face, phone, video or email.

Critical incident support
Receive immediate critical incident support during times of trauma or crisis. Our wide-ranging approach provides stabilization and reduces stress associated with incidents of trauma or violence.

Legal and financial referral services
Whether it's help buying a home, handling a legal dispute or creating a comprehensive financial plan, we will refer you to a third-party advisor who can help answer your questions and reach your goals.

Access to the wellness website and app
Discover online support, tools and articles for help and advice on health and wellbeing.

Let us help:

+1 905 886 3605

This is not a free phone number. If you need a local number, please access the wellness website and you will find the full list of our 'International Numbers'.

Your calls are answered by an English-speaking agent, but you can ask to talk to someone in a different language. If an agent is not available for the language you need, we will organise interpreter services.

https://www.allianzcare.com/eap-login (available in English, French and Spanish)

Download the Lifeworks app in Google Play or Apple Store:

Download on the App Store GET IT ON Google Play

Login on the website or the app using the following details:

Username: AllianzCare
Password: Expatriate

Travel Security Services**

As the world continues to witness an increase in security threats, Travel Security Services offer 24/7 access to personal security information and advice for your travel safety queries - via phone, email or website. Your Table of Benefits shows whether your plan includes these services.

You can access:

Emergency security assistance hotline
Talk to a security specialist for any safety concerns associated with a travel destination.

Country intelligence and security advice
Security information and advice about many countries.

Daily security news updates and email travel safety alerts
Sign up and receive alerts about high-risk events in or near your current location, including terrorism, civil unrest and severe weather risks.

To access the travel security services, please contact us:

+44 207 741 2185

This is not a free phone number.

allianzcustomerenquiries@worldaware.com

https://my.worldaware.com/awc

Register by entering your policy number (shown in your Insurance Certificate)

Download 'TravelKit' app from App store or Google Play.

Download on the App Store

GET IT ON Google Play

All Travel Security Services are provided in English. We can arrange for you to use an interpreter where required.

*** Certain services which may be included in your plan are provided by third party providers outside the Allianz Group, such as the Employee Assistance Programme, Travel Security services, HealthSteps app, Second Medical Opinion and tele-medicine services. If included in your plan, these services will show in your 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 HealthSteps app does not provide medical or health advice and the wellness resources contained within Olive are for informational purposes only. The HealthSteps 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 AWP Health & Life SA (Qatar Branch) and AWP Health & Life Services Limited 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.*

Understanding how your cover works

What am I covered for?

You and your dependants are covered for medically necessary treatment and related costs, services and/or supplies as indicated in the Table of Benefits. These are subjected to:

- Policy definitions and exclusions (available in this guide).
- **For policies with full medical underwriting:** Any special conditions shown on your Insurance Certificate (and on the Special Condition Form issued before the policy comes into effect, where relevant).
- **Costs being reasonable and customary:** these are costs that are usual within the country of treatment. We will only reimburse medical providers where their charges are in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline or reduce the amount we pay.

We generally cover pre-existing conditions (including pre-existing chronic conditions) unless we say otherwise in your policy documents. If in doubt, please check your Table of Benefits to confirm if pre-existing conditions are covered.

If you are uncertain whether your planned medical treatment is covered under your plan, please contact our Helpline.

Where can I receive treatment?

You can receive treatment in any country within your area of cover, as shown on your Access Card.

If the treatment you need is available locally, but you choose to travel to another country in your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; except for your travel expenses. If the eligible treatment is not available locally, and your cover includes the appropriate "Medical evacuation" benefit, we will also cover travel costs to the nearest suitable medical facility. To claim for medical and travel expenses incurred in these circumstances, you will need to complete and submit the Pre-authorisation Form before travelling.

You are covered for eligible costs incurred in your home country, provided that your home country is in your area of cover.

What are benefit limits?

Your cover may be subject to a **maximum plan benefit**. This is the maximum we will pay in total for all benefits included in the plan per member, per Insurance Year.

If your plan has a maximum plan benefit, it will apply even where:

- The term "Full refund" appears next to the benefit.
- A specific benefit limit applies - this is when the benefit is capped to a specific amount (e.g. US$6,000).

Benefit limits may be provided on a "per Insurance Year" basis, on a "per lifetime" basis or on a "per event" basis (such as per trip, per visit or per pregnancy).

In some instances, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit (e.g. 65% refund, up to US$7,100).

Benefit limits related to maternity

The benefits "**Routine maternity**" and "**Complications of pregnancy and childbirth**" are paid on either a "per pregnancy" or "per Insurance Year" basis. Your Table of Benefits will confirm this.

If your maternity benefits are payable on a "per pregnancy" basis

When a pregnancy spans two Insurance Years and the benefit limit changes at policy renewal, the following rules apply:

- In year one – the benefit limits apply to all eligible expenses.
- In year two – the updated benefit limits apply to all eligible expenses incurred in the second year, less the total benefit amount already reimbursed in year one.
- If the benefit limit decreases in year two and we have already paid up to or over this new amount for eligible costs incurred in year one, we will pay no additional benefit in year two.

Limit for multiple-birth babies, all babies born by surrogacy, adopted and fostered children

There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- was born by surrogacy
- is adopted
- is fostered
- is a multiple-birth baby born as a result of medically assisted reproduction.

This limit is US$40,500 per child and it applies before any other benefit in your plan.
Out-patient treatment is paid under the terms of the Out-patient Plan.

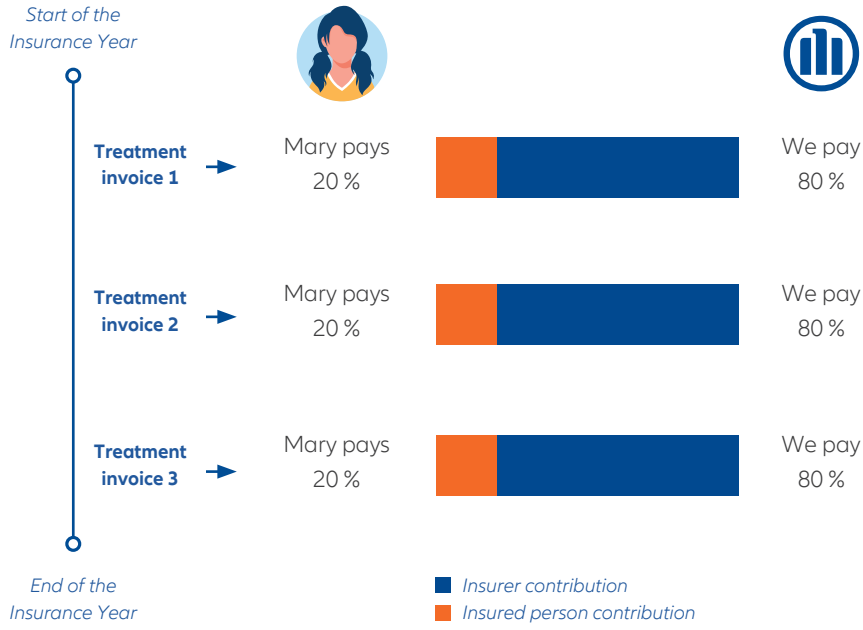
Your Access Card

We issue a personal Access Card to every insured member, which contains essential contact numbers. This means that you and your family are only a phone call away from help. For this reason, we suggest that you keep this card with your at all times.

The Access Card aims to establish your identity and allows you to access the network of clinics, hospitals and pharmacies assigned to your healthcare plan. It is not transferrable and you must return it or destroy it when membership ends. The validity of the card is subject to continuity of membership.

What are co-payments?

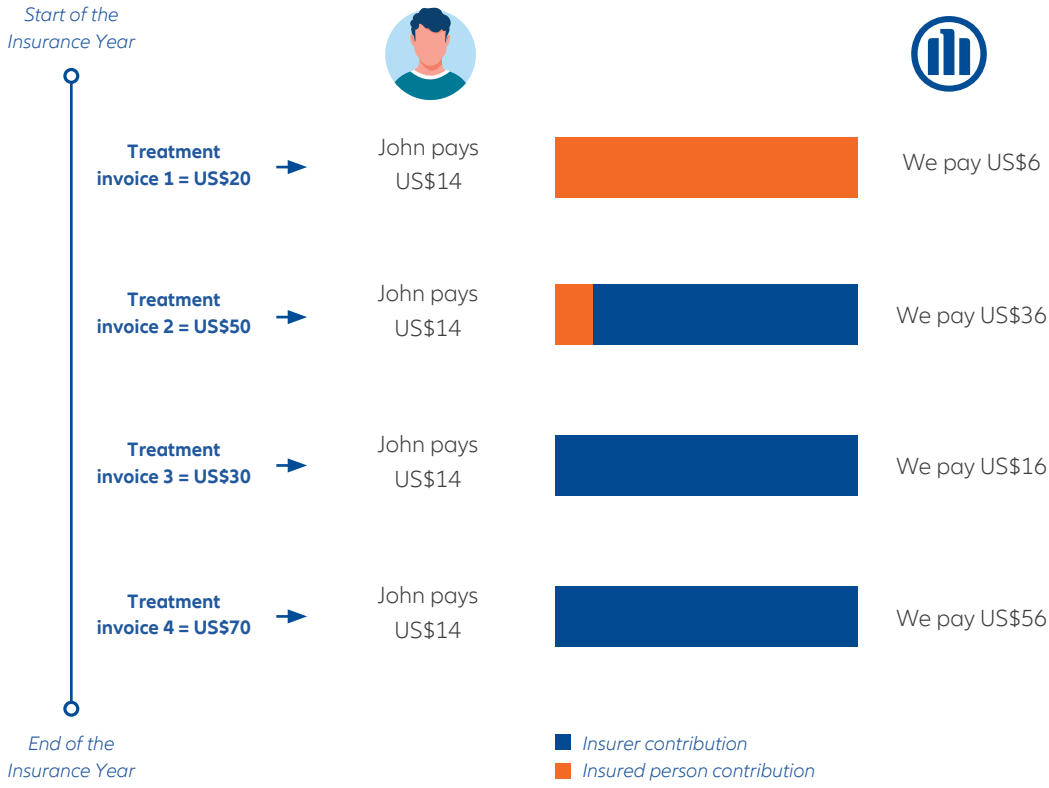
A **co-payment** is when you pay a percentage of the medical costs. Your Table of Benefits will show whether this applies to your plan. In the following example, Mary requires several dental treatments throughout the year. Her dental treatment benefit has a 20% co-payment, which means that we will pay 80% of the cost of each eligible treatment.



The total amount payable by us may be subject to a maximum plan benefit limit.

What are deductibles?

A **deductible** (also known in health insurance as an 'excess') is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute. It applies per person, per out-patient visit. Your Table of Benefits will show whether this applies to your plan. In the following example, John needs to receive medical treatment throughout the year. His plan includes a US$14 deductible.



Seeking treatment?

We understand that seeking treatment can be stressful. Follow the steps below so we can look after the details – while you concentrate on getting better.

If you go to a **network hospital/clinic**, they will contact us directly for the necessary pre-approval. A list of the hospitals and clinics in your company's chosen network is provided as part of your Membership Pack.

If you select a **hospital or clinic outside of the network, or outside of Qatar**, you and your doctor need to complete the relevant sections of a Pre-authorisation Form and then send it to us for approval before treatment. Please contact us **at least five working days before receiving treatment** so that we can ensure that there will be no delays at the time of admission. A copy of the Pre-authorisation Form is included in your Membership Pack and you can download additional copies from our website.

Treatment within the Qatar provider network

If your area of cover includes Qatar, you have access to a complete network of medical providers based in Qatar. Please refer to the providers network list sent with your Membership Pack to find out what providers are included in the network.

Accessing treatment:

When visiting a network medical provider, simply present your Access Card.

The provider will contact us directly to process the necessary paperwork.

We will settle the bill directly with your medical provider.

Please note that unless otherwise stated in your Table of Benefits, cover for the following benefits (if provided) is available on a reimbursement basis only, i.e. you will have to pay for eligible treatment and then claim from us:

- Acupuncture
- Chiropractic treatment
- Health and wellbeing checks including screening for the early detection of illness or disease
- Homeopathy
- Medical aids

- Podiatry
- Psychiatry

If you need to buy prescribed medication, your treating doctor will give you a Pharmacy Services Claim Form along with your prescription. When you present the Pharmacy Services Claim Form to a pharmacy included in your network, you will not be required to make any payment for the prescribed medicines (subject to the limits of your cover).

Treatment outside of the Qatar provider network or outside of Qatar

Check your level of cover

First, check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm what is covered. However, you can always call our Helpline if you have any queries.

Some treatments require pre-approval

Your Table of Benefits will show which treatments require pre-approval (via a Pre-authorisation Form). These are mostly in-patient and high cost treatments. The pre-approval process helps us assess each case, organise everything with the hospital before your arrival and make direct payment of your hospital bill easier, where possible.

Unless we and your company agree otherwise, if you make a claim without obtaining our pre-approval, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.
- If the treatment is subsequently proven to be medically necessary, we will pay 80% of in-patient benefits and 50% of other benefits.

Getting in-patient treatment (pre-approval applies)

Download a Pre-authorisation Form from our website: **www.allianzcare.com/members**

Complete the form and send it to us at least five working days before treatment. You can send it by email, fax or post to the address shown on the form.

We contact the hospital to organise payment of your bills directly, where possible.

If it's an emergency:

Get the emergency treatment you need and call us if you need any advice or support.

If you are hospitalised, either you, your doctor, one of your dependants or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalisation. We can take Pre-authorisation Form details over the phone when you call us.

We can also take Pre-authorisation Form details over the phone if treatment is taking place within 72 hours. Please note that we may decline your claim if Pre-approval is not obtained. For full details of our Pre-approval process see the 'Terms and Conditions' section of this guide.

Claiming for your out-patient, dental and other expenses

If your treatment does not require pre-approval, you can simply pay the bill and claim the expenses from us. In this case, follow these steps:

Receive your medical treatment and pay the medical provider.

Get an invoice from your medical provider. This should state your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.

Claim back your eligible costs via our MyHealth app or online portal (**www.allianzcare.com/en/myhealth.html**).

Simply enter a few key details, add your invoice(s) and press 'submit'.

Quick claim processing

Once we have all the information required, we will process and pay a claim. However, we can only do this if you have told us your diagnosis, so please make sure you include this with your claim. Otherwise, we will need to request the details from you or your doctor.

We will email or write to you to let you know when the claim has been processed.

Evacuations and repatriations

At the first indication that you need medical evacuation or repatriation, please call our 24 hour Helpline and we will take care of it. Given the urgency, we would advise you to phone if possible. However, you can also contact us by email. If emailing, please write 'Urgent – Evacuation/Repatriation' in the subject line.

Please contact us before talking to any providers, even if they approach you directly, to avoid excessive charges or unnecessary delays in the evacuation. In the event that evacuation/repatriation services are not organised by us, we reserve the right to decline the costs.

8000 155 (calling toll-free from within Qatar)
+974 4031 8444 (calling from within or outside of Qatar)

medical.services@allianzworldwidecare.com

Seeking treatment in the USA

If you have worldwide cover, we offer you simple access to medical care in the USA, through our local third-party partner, supporting your access to medical providers in the country.

To access treatment in the US, simply show your membership card: your medical provider will then contact our third-party partner to sort any paperwork related to your treatment. The cost of your eligible treatment will be paid to your medical provider, if applicable; if you are responsible for any part of the costs, your provider will let you know.

For queries or requests for assistance related to treatment in the USA, please find all contact details on the back of your membership card.

For a prescription

If your plan includes access to the Caremark's pharmacy network, you can obtain certain drugs and pharmacy products at these US pharmacies on a cashless basis. All details you need to access the Caremark pharmacy network will be shown either on your membership card or on a separate Caremark card.

Show your membership card (or the separate Caremark card) to the Caremark network pharmacy.
The pharmacist will tell you if you need to pay any part of the costs, for example if there is a co-payment.
Please ensure that the prescriptions have the date of birth of the person that the prescription is for.

Additional information about claiming for your expenses

Medical claims

Before submitting a claim to us, please pay attention to the following points:

- **Claiming deadline:** You must submit all claims (via our MyHealth app or online portal) no later than six months after the end of the Insurance Year. If cover is cancelled during the Insurance Year, you should submit your claim no later than six months after the date that your cover ended. After this time, we are not obliged to settle the claim.

- **Claim submission:** You must submit a separate claim for each person claiming and for each medical condition being claimed for.

- **Supporting documents:** When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/ receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.

- **Deductibles:** If the amount you are claiming is less than the deductible figure in your plan, you can either:

  - Collect all out-patient receipts until you reach an amount that exceeds this deductible figure.
  - Send us each claim every time you receive treatment. Once you reach the deductible amount, we'll start reimbursing you.

  Attach all supporting receipts and/or invoices with your claim.

- **Currency:** Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued, or on the date that we pay your claim.

  Please note that we reserve the right to choose which currency exchange rate to apply.

- **Reimbursement:** We will only reimburse (within the limits of your policy) eligible costs after considering any pre-approval requirements, deductibles or co-payments outlined in the Table of Benefits.

- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.

- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.

- **Providing information:** You and your dependants agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.

Claims for accidental death

If the "Accidental death" benefit is included in your healthcare plan, the claim must be reported to us within 90 working days following the date of death of the insured person.

Please send us:

- A fully completed Life and Accidental Death Benefit Application Form.
- A death certificate.
- A medical report indicating the cause of death.
- A written statement outlining the date, location and circumstances of the accident.
- Official documentation proving the insured person's family status (i.e. whether they are married or have children).
- For the beneficiaries, proof of identity as well as proof of their relationship to the insured person.

Beneficiaries are, unless otherwise specified by the insured:

- The insured person's spouse or partner, if not legally separated.
- If there is no spouse, the insured person's surviving children including step-children, adopted or foster children and children born less than 300 days after the date of the insured person's death; in equal shares among them.
- If there are no children, the insured person's father and mother, in equal shares between them, or to the survivor if one parent has died.
- Failing any of the above, the insured person's estate.

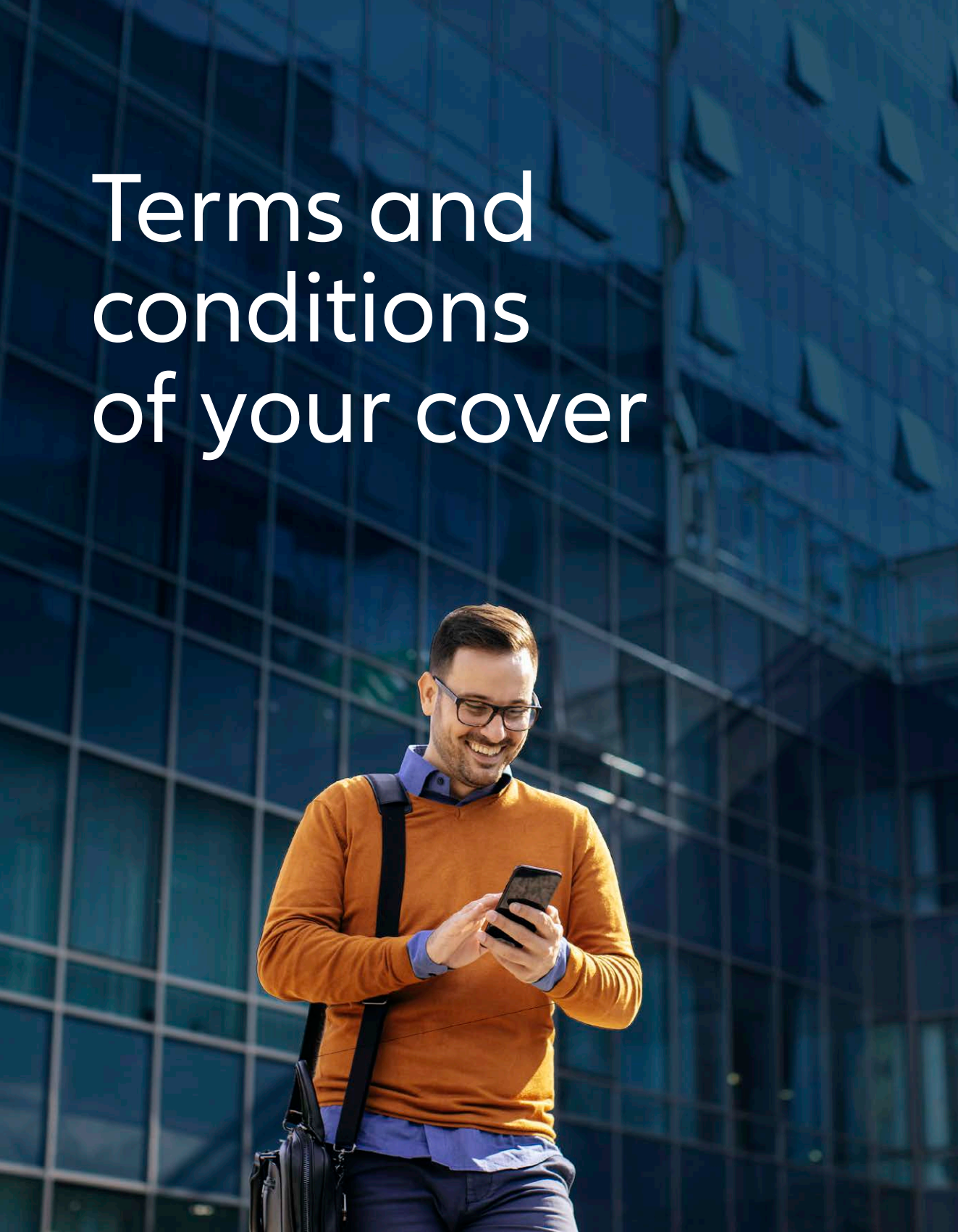
If you wish to nominate a beneficiary other than those listed above, please contact our Helpline.

Please note that if the insured person and one or all of the beneficiaries die in the same incident, the insured person will be considered the last deceased.

Treatment needed as a result of someone else's fault

If you are claiming for treatment that you need when somebody else is at fault, you must write and tell us as soon as possible. For example, if you need treatment following a road accident in which you are a victim. Please take any reasonable steps we ask of you to obtain the insurance details of the person at fault. We can then recover from the other insurer the cost of the treatment paid for by us. If you are able to recover directly the cost of any treatment which we have paid for, you will need to repay that amount (and any interest) to us.

Terms and conditions of your cover



Terms and conditions

This section describes the benefits and rules of your health insurance policy. Please read it together with your Insurance Certificate, Access Card and Table of Benefits.

- Your **Insurance Certificate** details the plan(s) and geographical area of cover that your company chose for you and your dependants (if applicable). It also states the start date and renewal date of your cover. For policies with full medical underwriting, this document will state any special terms that may apply to your cover. Please note that we will send you a new Insurance Certificate if we need to record any changes to your policy. These may be changes that your company requests or changes we are entitled to make. They may also be changes that you request (such as adding a dependant) – provided your company approves and we accept.

- Your **Access Card** contains the details of your cover and your personal details. It aims to establish your identity and allows you to access the network of clinics, hospitals and pharmacies assigned to your healthcare plan. Acceptance and use of the Access Card automatically implies acceptance of all terms, conditions, limitations and exclusions of this policy. Please note that we will send you a new Access Card if we need to record any changes to your policy. These may be changes that your company requests or changes we are entitled to make. They may also be changes that you request (such as adding a dependant) – provided your company approves and we accept. Your new Access Card(s) will replace any earlier version(s) you have from the start date shown on it. You must destroy or return to us earlier versions.

- Your **Table of Benefits** outlines the plan(s) selected by your company and the benefits available to you. It also specifies any benefits/treatments that require submission of a Pre-authorisation Form. It confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply. Your Table of Benefits will be in US Dollars or Qatar Riyals, depending on the agreement with your company.

For full details of your company's insurance contract, please contact your company's Group Scheme Manager. Please note that the terms and conditions of your cover may be changed from time to time by agreement between your company and us.

Administration of your policy

When cover starts for you and your dependants

Your insurance is valid from the start date shown on the Access Card and will continue until the group renewal date (which is also stated on the Access Card). Generally, this is one Insurance Year, unless we and your company decide otherwise or if you started your policy mid-year. At the end of this period, your company can renew the insurance on the basis of the policy terms and conditions applicable at that time. You will be bound by those terms.

Cover for dependants (if applicable) will start on the effective date shown on your most recent Insurance Certificate which lists them as your dependants. Their membership may continue for as long as you remain part of the group scheme and, for children, as long as they remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday or up until the day before their 26th birthday if they are in full-time education. At that time, they may apply for cover in their own right under one of our Healthcare Plans for Individuals and Families.

Adding dependants

Are you getting married or having a baby? Congratulations!

You may apply to include any member of your family as a dependant if you are allowed to under the agreement between your company and us. The process is different for policies with full medical underwriting, moratorium and non-underwritten policies, as outlined below: please refer to your Insurance Certificate to confirm what underwriting terms apply to your policy. Also, if the dependant you want to add is a newborn, please check the paragraph about 'In-patient treatment limits for newborn dependants' further below.

Policies with full medical underwriting

You may apply to add a family member in your policy by completing the relevant application form. Your new dependant will be subject to medical underwriting and, if accepted, cover will start from the date of acceptance.

However, if the dependant you want to add is a newborn, please follow the guidelines below.

- How do I add a newborn to my policy?
  Please send an email to underwriting@allianzworldwidecare.com within four weeks from birth and attach the birth certificate. With the exception of multiple birth babies, we will accept the baby without medical underwriting if the birth parent or intended parent (in the case of surrogacy) has been insured with us for a minimum of eight continuous months. Cover will start at birth.

- What happens if I don't notify you within four weeks?
  The newborn child will be underwritten and if accepted, cover will start from the date of acceptance.

- What if I am adding multiple birth babies?
  Multiple birth babies will be underwritten and if accepted, cover will start from the date of acceptance.

Policies with moratorium

Simply contact us to request the addition of a family member to your policy. There is no need to complete an application form and we'll cover the new dependant from the date on which you notify us or from a later date that you may request – a new moratorium will apply for that dependant.

However, if the dependant you want to add is a newborn who is less than four weeks old, but we have not covered either of their parents for a continuous period of at least eight continuous months, you will need to complete the relevant application form. We will review the application form, confirm the date we agree to add the newborn and a new moratorium will apply for him/her.

Non-underwritten policies

To add a family member as a dependant on your policy, simply notify your company and they will organize it with us.

However, if the dependant you want to add is a newborn, please follow the guidelines below.

- How do I add a newborn to my policy?
  Newborn infants (including multiple birth babies, babies born by surrogacy, adopted and fostered children) will be accepted for cover from birth, provided that we are notified within four weeks of the date of birth. To have a newborn added to the policy, you must ask your company to submit a request in writing, including a copy of the birth certificate, to its usual contact person for membership changes.

  Following acceptance, we will issue a new Insurance Certificate to reflect the addition of a dependant. This new certificate will replace any earlier version(s) you may have from the start date shown on it.

- What happens if I don't notify my company within four weeks?
  If we are notified four weeks or more after the date of birth, newborn children will be accepted for cover from the date of that notification.

In-patient treatment limits for newborn dependants

There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- was born by surrogacy
- is adopted
- is fostered
- is a multiple-birth baby born as a result of medically assisted reproduction.

This limit is US$40,500 per child and it applies before any other benefit in your plan.
Out-patient treatment is paid under the terms of the Out-patient Plan.

Changing country of residence

It is important that you contact our Helpline and notify your Group Scheme Manager to let us know when you change your country of residence. This may affect your cover or premium, even if you are moving to a country within your geographical area of cover, as your existing plan may not be valid there. Cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Changing your postal address or email address

We will send all correspondence to the address we have on record for you unless requested otherwise. You need to inform us in writing as soon as possible of any change in your home, business or email address.

Correspondence

When you write to us, please use email or post (with the postage paid). We do not usually return original documents to you, but if you ask us to, we will.

Renewal of cover

If your company pays for your premium, the renewal of your cover (and that of your dependants, if applicable) is the decision of your company.

If you pay your premium and your company renews your cover (and that of your dependants, if applicable), your policy will automatically renew for the next Insurance Year, if:

- We can continue to provide cover in your country of residence
- All premiums due to us have been paid
- The payment details we have for you are still valid on the policy renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

Upon renewal, you (and each of your dependants, if applicable) will receive new Access Cards to use until the next renewal date (and you must destroy or return to us any previous card versions).

Ending your cover

Your company can end your cover or that of any of your dependants by notifying us in writing. We cannot backdate the cancellation of your cover. It will automatically end:

- At the end of the Insurance Year, if the agreement between your company and us is terminated.
- If your company decides to end or not to renew your cover.
- If your company does not pay premiums or any other payment due under the Company Agreement with us.
- If you are an individual payer and you do not pay premiums or any other payment due under the Company Agreement with us.
- When you stop working for your company.
- Upon the death of the insured employee.

We can end your cover and that of your dependants if there is reasonable evidence that you or they have misled or attempted to mislead us. For example giving us false information, withholding information, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

- Whether you (or they) can join the scheme
- What premiums your company has to pay
- Whether we have to pay any claim

Policy expiry

Please note that upon the expiry of your policy, your right to reimbursement ends. For up to six months after the expiry date, we will reimburse any eligible expenses incurred during the period of cover. However, we will no longer cover any on-going or further treatment that is required after the expiry date of your policy.

It is your responsibility to ensure that any access card provided to you or your dependents is destroyed immediately when your membership ends. If you or your dependent(s) obtain treatment following the expiry of membership, we reserve the right to recover the full amount of any treatment expenses from you and/or your company.

Applying for cover if group membership ends

If your cover under the Company Agreement comes to an end, you can apply for cover under one of our Healthcare Plans for Individuals and Families, by simply sending us an email (details below). You need to submit your application within one month of leaving the group scheme. You may be subject to underwriting. If we accept your application, cover will start on the first day after you leave the group scheme.

@ individual.sales@allianzworldwidecare.com

Paying premiums

If your company pays your insurance premium

In most cases, your company is responsible for paying the premiums for you and your dependants, covered under the Company Agreement. Your company may also pay other taxes and charges associated with your cover (such as Insurance Premium Tax). However you may be liable to pay tax in respect of the premiums paid by your company. For details, please check with your company.

If you pay your insurance premium

If you are responsible for paying your insurance premium, you need to pay us in advance for the duration of your cover. Your Insurance Certificate shows the amount your company has agreed with us and your selected payment frequency. The **initial premium** or first premium instalment is payable immediately after we accept your application. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for payments made through third-parties. **Subsequent premiums** are due on the first day of the chosen payment period.

If applicable, you may also need to pay the following taxes in addition to your premium:

- Insurance Premium Tax (IPT).
- VAT.
- Other taxes, levies or charges relating to your cover that we may have to pay or collect from you by law.

These charges may already be in effect when you join but they could be introduced (or change) afterwards. Your invoice will show these taxes. If they change or if new taxes are introduced, we will write to inform you. If you do not accept the changes, you can choose to end your cover. We will not apply any of the changes if you end your membership within 30 days of the date they take effect, or within 30 days of us telling you about the changes (whichever is later).

In some countries you may also be required to apply withholding tax. If that is the case, it is your responsibility to calculate and pay this amount to the relevant authorities in addition to payment of your full premium to us.

Each year on the renewal date, we may change how we calculate your premiums and taxes, the amount you have to pay and/or the method of payment. If so, we will inform you of these changes and they will only apply from your renewal date. If you wish, you can change the way you pay at policy renewal. Please write to us to request this at least 30 days before the renewal date.

If you are unable to pay your premium for any reason, please contact us so that we can discuss this with you, as if you don't pay your premiums on time you may lose your cover.

The following terms also apply to your cover

Applicable law: membership is governed by the law of the Qatar Financial Centre. Any dispute that cannot otherwise be resolved will be dealt with by courts of the Qatar Financial Centre.

Economic sanctions: Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

Who is covered: Only those group members (and dependants) as described in the Company Agreement are eligible for cover.

The amounts we will pay: Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.

Who can make changes to your policy: No-one, except an appointed representative or the Group Scheme Manager is allowed to make changes to your policy on your behalf. Changes are only valid when agreed by your company and us.

When cover is provided by someone else: We may decline a claim if you or any of your dependants are eligible to claim benefits from:

- A public scheme
- Any other insurance policy
- Any other third-party

If that is the case, you need to inform us and provide all necessary information. You and the third party cannot agree any final settlement or waive our right to recover expenses without our prior written agreement. Otherwise, we are entitled to get back from you any amount we have paid and to cancel your cover.

We have the right to claim back from a third party any amount we paid for a claim, if the costs were due from or also covered by them. We may take legal proceedings in your name, at our expense, to achieve this. This is called subrogation.

We will not make a contribution to any third-party insurer if the costs are fully or partly covered by that insurer. However, if our plan covers a higher amount than the other insurer, we'll pay the amount not covered by them.

Circumstances outside of our control (force majeure): We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things which are outside of our reasonable control. Examples are extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage and expropriation by governmental authorities.

Cancellation and fraud:

a) **For policies with full medical underwriting**, the information you and your dependants give us e.g. on the Application Form or supporting documents, needs to be accurate and complete. If it isn't correct or if you don't tell us about things that may affect our underwriting decision, it may invalidate your policy from the start date. You also need to tell us about any medical conditions that arise between completing the application form and the start date of the policy. Medical conditions that you don't tell us about will most likely not be covered. If you're not sure whether certain information is relevant to underwriting, please call us and we'll be able to clarify.

b) **For policies with moratorium**, moratorium cover will still apply even if you tell us about any pre-existing medical conditions you might have. We may apply new terms to the plan, void or cancel it and/or reduce or reject any related claims, based on your new material facts.

c) We will not pay any benefits for a claim if:
   - The claim is false, fraudulent or intentionally exaggerated.
   - You or your dependants or anyone acting on your or their behalf use fraudulent means to obtain benefit under this policy.

The amount of any claim we paid to you before the fraudulent act or omission was discovered will become immediately owing to us. We reserve the right to inform your company of any fraudulent activity.

Making contact with dependants: In order to administer your policy, we may need to request further information. If we need to ask about one of your dependants (e.g. when we need to collect an email address for an adult dependant), we may contact you as the person acting on behalf of the dependant, and ask you for the relevant information, provided it is not sensitive information. Similarly, for the purposes of administering claims, we may send you non-sensitive information that relates to a family member.

Use of Medi24: The Medi24 advice line and its health-related information and resources is extremely helpful, but it's not a substitute for professional medical advice or for the care that you receive from your doctor. It is not intended to be used for medical diagnosis or treatment and you should not rely on it for that purpose. Always seek the advice of your doctor before beginning any new treatment or if you have any questions about a medical condition. We are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of Medi24 or the information or services provided by them. Calls to Medi24 will be recorded and may be monitored for training, quality and regulatory purposes.

Data protection

Our Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice visit:

www.allianzcare.com/en/privacy.html

Alternatively, you can contact us on the phone to request a paper copy.

+353 1 630 1301

If you have any queries about how we use your personal data, please email us at:

AP.EU1DataPrivacyOfficer@allianz.com

Complaints and dispute resolution procedure

Our Helpline is always the first number to call if you have any comments or complaints. If we can't resolve the problem on the phone, please email or write to us:

8000 155
+974 4031 8444

client.services@allianzworldwidecare.com

We will handle your complaint according to our internal complaint management procedure.
For details see:

www.allianzcare.com/complaints-procedure

You can also contact our Helpline to obtain a copy of this procedure.

If we can't resolve the matter to your satisfaction and you wish to take it further, you can refer your complaint to the Qatar Financial Centre's Customer Dispute Resolution Scheme. The Customer Dispute Resolution Scheme is an independent body authorised to arbitrate between companies regulated by the Qatar Financial Centre Regulatory Authority and their customers.

complaints@cdrs.org.qa

Customer Dispute Resolution Scheme, PO Box 22989, Doha, Qatar

Definitions

The following definitions apply to our Healthcare Plans. The benefits you are covered for are listed in your Table of Benefits. If your plan includes any benefit not listed below, the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy documents, they will always have the following meanings:

A

Accident is a sudden, unexpected event that causes injury and is due to a cause external to the insured person. The cause and symptoms of the injury must be medically and objectively definable, allow for a diagnosis and require therapy.

Accidental death benefit refers to an amount shown in the Table of Benefits which becomes payable if an insured person (aged 18 to 70) dies during the period of insurance as a result of an accident (including an industrial injury).

Accommodation costs for one parent staying in hospital with an insured child refers to the hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, phone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

Acute refers to the sudden onset of symptoms or a medical condition.

Acute medical condition is a medical condition that is brief, has a definite end point, and, in our reasonable opinion, based on advice or general advice can be cured by treatment.

Allergy testing refers to a visit to a licensed practitioner to test for and discover if your symptoms are related to an allergy. If included in your plan as a specific benefit, cover is limited to the amount shown in your Table of Benefits.

Assisted conception is a pregnancy that is conceived following fertility treatment, including pregnancies conceived through Intrauterine Insemination, In Vitro Fertilisation (IVF) or any other Assisted Reproductive Technology, and pregnancies conceived within one month of using fertility medication.

Ayurvedic treatment refers to treatment and medication administered by approved therapists on an out-patient basis to treat eligible medical conditions. Cover is limited to the amount indicated on the Table of Benefits.

B

Burial expenses refer to the cost of burials or cremation that take place outside the home country or principal country of residence. It doesn't include related ceremonial costs such as food and beverage, travel, accommodation, flowers and sympathy cards.

C

Cancer screening for the early detection of illness or disease are health checks, tests and examinations, performed at appropriate age intervals, that are undertaken without any clinical symptoms being present. Please refer to your Table of Benefits to confirm what tests and checks are covered under this benefit.

Child hearing exam provides a contribution towards the services of a suitably qualified and recognised hearing care professional in the country of treatment. To be eligible for this benefit, your child must be 16 years or younger and covered at the time they receive the service. When submitting a claim, please attach a dated invoice from the provider.

Chronic condition is defined as a sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also has one or more of the following characteristics:

- Is recurrent in nature
- Is without a known, generally recognised cure
- Is not generally deemed to respond well to treatment
- Requires palliative treatment
- Leads to permanent disability

Please refer to the "Notes" section of your Table of Benefits to confirm whether chronic conditions are covered.

Company is your employer as named in the Company Agreement.

Company Agreement is the agreement we have with your employer, through which you and your dependants are insured with us. This agreement sets out who can be covered, when cover begins, how it is renewed and how premiums are paid.

Complementary treatment refers to therapeutic and diagnostic treatment that exists outside of traditional Western medicine. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture, podiatry and ayurvedic treatment as practised by approved therapists.

Complications of childbirth refers only to post-partum haemorrhage and retained placental membrane. Where your plan also includes a routine maternity benefit, complications of childbirth includes medically necessary caesarean sections.

Complications of pregnancy relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: gestational diabetes, pre-eclampsia, stillbirth and hydatidiform mole. Please note that where an ectopic pregnancy, miscarriage or threatened miscarriage arises, cover is provided under the member's non-maternity healthcare benefits.

Congenital conditions refers to any abnormality, deformity, disease, disorder, illness, malformation, defect, anomaly or injury that is hereditary or acquired before or during birth. A congenital condition can be diagnosed at birth or later in life.

Co-payment is the percentage of the costs which you must pay. E.g. if a benefit has a 80% refund, this means that a co-payment of 20% applies, therefore we will pay 80% of the costs of each eligible treatment per insured person, per Insurance Year.

CPME/CTT stands for Continuous Personal Medical Exclusions and for Continuous Transfer Terms. These acronyms refer to the continuation of the same underwriting terms, including any special exclusions and/or surcharges, that applied with your previous insurer. You will not be subject to any new personal underwriting terms. Cover will still be governed by the benefits, terms and conditions of the plan with us. The underwriting terms with us can be CPME/CTT previously MORI or CPME/CTT previously FMU. See the 'CPME/CTT previously MORI' and 'CPME/CTT previously FMU' definitions for more information.

CPME/CTT previously FMU refers to the continuation of your full medical underwriting terms that you had with a previous insurer. Cover will still be governed by the benefits, terms and conditions of the plan with us.

CPME/CTT previously MORI is the continuation of your moratorium start date if you had moratorium underwriting terms with a previous insurer. Cover will still be governed by the benefits, terms and conditions of the plan with us.

D

Day-care treatment is planned 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 and where a discharge note is issued.

Deductible also referred to as 'excess' in health insurance, is the part of the cost that is payable by you and that we deduct from the amount we will pay.

Where deductibles apply, they are payable per person per Insurance Year, unless your Table of Benefits states otherwise.

Dental implants refers to prostheses that interface with the bone of the jaw or the skull to support a dental prosthesis such as a crown, bridge or denture. Cover is only provided where your plan includes a specific 'Dental implants' benefit.

Dental practitioner is a person who:

- has attained primary degrees in dentistry and/or dental surgery by attending a dental and/or medical school recognised by a relevant accredited professional body, and
- is licensed by the relevant authority to practice dentistry and/or dental surgery in the country where the treatment is given.

Dental prescription drugs refers to those prescribed by a dentist for the treatment of dental inflammation or infection. The prescription drugs must be proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. They do not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

Dental prostheses includes crowns, inlays, onlays, adhesive reconstructions/restorations, bridges and dentures, as well as all necessary and ancillary treatment required. Dental implants are not covered under the 'Dental prostheses' benefit, but may be included in your cover under a separate 'Dental implants' benefit.

Dental surgery includes the surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants.

Dental treatment includes an annual check-up, simple fillings related to cavities or decay, root canal treatment and dental prescription drugs.

Dependant is your spouse or partner and unmarried children that are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 26th birthday if they are in full-time education.

Diagnostic tests refers to investigations such as x-rays or blood tests, carried out for diagnostic purposes. These tests are covered when you are already displaying symptoms or when needed following other medical test results. This benefit does not cover annual check-ups or routine screenings.

Dietician fees relate to charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practise in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.

Direct family history exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

Direct settlement is where we settle costs of treatment or services directly with a medical provider in our medical provider network.

Doctor is a person who is licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

E

Effective date refers to the first day we cover you under the plan during the Insurance Year, as shown on your Insurance Certificate.

Emergency is the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

Emergency in-patient dental treatment refers to acute emergency dental treatment for the relief of pain that is due to a serious accident and requires admission to hospital. The treatment must take place within 24 hours of the emergency event. Cover does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

Emergency out-patient dental treatment is treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. However, if your policy also includes a Dental Plan, it will cover dental treatment in excess of the limit on 'Emergency out-patient dental treatment' benefit. In that case, the Dental Plan terms will apply.

Emergency out-patient treatment is treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed. If your policy includes out-patient benefits, they will cover you for out-patient treatment in excess of the limit on 'Emergency out-patient treatment' benefit.

Emergency treatment outside area of cover is treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided for up to six weeks per trip within the maximum benefit amount. It includes treatment required due to an accident or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. Please tell your company's Group Scheme Manager if you are going to be outside your area of cover for more than six weeks.

Expenses for one person accompanying an evacuated/repatriated person refer to the travel costs for one person accompanying the evacuated/repatriated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation/repatriation started from. Cover is not provided for hotel accommodation or other related expenses.

F

Family history exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

Foreseeable is a medical condition that, in our reasonable opinion, could be reasonably anticipated.

Full medical underwriting is the assessment of insurance risk based on information that you give us when applying for cover. Our underwriting team uses this information to decide the terms of our offer.

G

General advice is any medical opinion or medical recommendation from a relevant accredited professional body in relation to a medical condition or treatment which confirms, in our reasonable opinion, an established medical practice or opinion.

Group Scheme Manager is the designated representative of your company, who acts as the point of contact between the company and us for matters relating to the administration of the plan such as enrolment, premium collection and renewal.

Groups with full medical underwriting are groups where members' medical history is assessed.

H

Health and wellbeing checks including screening for the early detection of illness or disease are health checks, tests and examinations, performed at appropriate age intervals, that are undertaken without any clinical symptoms being present. Please refer to your Table of Benefits to confirm what tests and checks are covered under this benefit.

Home country is a country for which you hold a current passport or which is your principal country of residence.

Hormone replacement therapy refers to the use of female hormones for the relief of symptoms resulting from cessation of ovarian function, either at the time of the natural menopause or following surgical removal of the ovaries. Cover is provided for medical practitioner fees, specialists fees as well as prescription drug expenses.

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

Hospital accommodation refers to standard private or semi-private accommodation as shown in the Table of Benefits - deluxe, executive rooms and suites are not covered. The hospital accommodation benefit only applies when the hospitalisation is not related to any other in-patient benefit shown on the Table of Benefits. For example, if a member is hospitalised for cancer treatment, the hospital accommodation will be covered under the oncology benefit, and not under the hospital accommodation benefit. Examples of benefits that already include hospital accommodation (if included in your plan) are: Psychiatry and psychotherapy, Organ transplant, Oncology, Routine maternity, Palliative care and Long-term care.

I

Infertility treatment refers to all invasive investigative procedures necessary to establish the cause of infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. It also covers treatment such as InVitro Fertilisation (IVF), for diagnosed cases of infertility. We will cover the cost of treatment for the insured member who receives it, up to the limit indicated in the Table of Benefits. You can't claim under an insured spouse/partner's cover for costs that exceed your benefit limit.

All non-invasive investigative procedures undertaken to establish the cause of infertility are covered within the relevant benefit limits of the Out-patient Plan (if you have one). Examples of benefits that cover non-invasive investigations procedures are 'Diagnostic tests', 'Medical practitioner fees' and 'Specialist fees'.

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children in-patient treatment is limited to US$40,500 per child for the first three months following birth: this limit applies before any other benefit in your plan. Out-patient treatment is paid under the terms of the Out-patient Plan.

In-patient cash benefit is payable when you receive in-patient treatment for a medical condition that is covered by us but is free of charge for you, i.e. when the full cost of your treatment is funded by your national health service and no claim is made or paid by us under any section of this policy. In-patient cash benefit is limited to the amount specified in the Table of Benefits and is payable after you are discharged from hospital. This benefit does not apply where you receive treatment in a government hospital in Qatar.

In-patient treatment refers to treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate is a document we issue that outlines the details of your cover. It confirms that your company has a group insurance policy with us.

Insurance Year applies from the effective date of your policy, as shown on the Access Card and ends at the expiry date of the Company Agreement. The following Insurance Year coincides with the year that is defined in the Company Agreement.

Insured person is you and your dependants as stated on your Insurance Certificate.

L

Laser eye treatment refers to the surgical improvement of the refractive quality of the cornea using laser technology, including the necessary pre-operative investigations.

Lifetime limit is the total amount we'll pay for any eligible costs you incur during any time we cover you on any one or more plans with the same or equivalent benefits, even if there's a break in your cover.

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

Long-term care refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home.

M

Medical advice is any medical opinion, medical recommendation or information given by a medical professional.

Medical evacuation applies in the following scenarios:

- If the necessary treatment you are covered for is not available locally
- If adequately screened blood is unavailable in an emergency

We will evacuate you to the nearest appropriate medical centre (which may or may not be in your home country) by ambulance, helicopter or aeroplane. The medical evacuation should be requested by your doctor, and will be carried out in the most economical way that is appropriate to your medical condition. Following completion of treatment, we will also cover the cost of your return trip at economy rates to your principal country of residence.
If you can't travel or be evacuated for medical reasons following discharge from an in-patient episode of care, we will cover the reasonable cost of hotel accommodation in a private en-suite room for up to seven days. We do not cover costs for hotel suites, four or five-star hotel accommodation or hotel accommodation for an accompanying person.

If you are evacuated to the nearest appropriate medical centre for ongoing treatment, we will cover the reasonable cost of hotel accommodation in a private en-suite room. This cost must be more economical than the cost of a series of journeys between the nearest appropriate medical centre and your principal country of residence. Hotel accommodation for an accompanying person is not covered.

Where adequately screened blood is not available locally, we will, where appropriate, try to locate and transport screened blood and sterile transfusion equipment, if this is advised by the treating doctor and our own medical experts. We and our agents accept no liability if we are unsuccessful or if contaminated blood or equipment is used by the treating authority.

You must contact us at the first indication that you need an evacuation. From this point onwards, we will organise and coordinate the evacuation until you arrive safely at your destination of care. If evacuation services are not organised by us, we reserve the right to decline all costs incurred.

Note that you may be covered as well for 'Non-emergency medical evacuation', if this benefit appears listed in your Table of Benefits.

Medical necessity refers to medical treatment, services or supplies that fulfil all of the following:

a) Essential to identify or treat your condition, illness or injury
b) Consistent with your symptoms, diagnosis or treatment of the underlying condition
c) In accordance with generally accepted medical practice and professional standards of care in the medical community at the time (this does not apply to complementary treatment methods if they form part of your cover)
d) Required for reasons other than the comfort or convenience of you or your doctor
e) Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover)
f) Considered to be the most appropriate type and level of service or supply
g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition
h) Provided only for an appropriate duration of time

In this definition, the term "appropriate" means taking patient safety and cost effectiveness into consideration. In respect to in-patient treatment, "medically necessary" also means that diagnosis can't be made or treatment can't be safely and effectively provided on an out-patient basis.

Medical practitioners are doctors who are licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

Medical practitioner fees refers to fees charged for non-surgical treatment performed or administered by a medical practitioner.

Medical provider network refers to all of the medical providers with whom we have arrangements in place for the direct settlement of our members' medical costs.

Medical repatriation is an optional level of cover and where provided will be shown in the Table of Benefits. If the necessary treatment for which you are covered isn't available locally you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is within your geographical area of cover. Following completion of treatment, we will also cover the cost of your return trip at economy rates, to your principal country of residence. The return journey must take place within one month after treatment has been completed.

You must contact us at the first indication that repatriation is required. From this point onwards we will organise and coordinate all stages of the repatriation until you arrive safely at your destination of care. If the repatriation is not organised by us, we reserve the right to decline all costs incurred.

Mental health professional is a practitioner working in health care, counselling or social services who offers services for the purpose of treating mental health conditions.

Midwife fees refers to fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has completed the necessary training and passed the necessary state examinations.

Moratorium (MORI) is a waiting period of 24 months from either your start date or the date shown in the special terms section of your Insurance Certificate that must have passed before claims for any pre-existing medical conditions may become eligible under the plan. This includes the underwriting term CPME/CTT previously MORI. Once you've completed a continuous 24-month period after your start date, your pre-existing medical condition may be covered, provided that you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

N

Natural tooth refers to any tooth that is original, not an artificial implant or replacement.

Newborn care includes 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.

Cover doesn't include further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant). For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to US$40,500 per child for the first three months following birth: this limit applies before any other benefit in your plan. Out-patient treatment is paid within the terms of the Out-patient Plan.

Non-underwritten groups are groups where the members' health information is not assessed.

Nursing at home or in a convalescent home refers to nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will pay the benefit listed in the Table of Benefits if the treating doctor decides that it is medically necessary for you to stay in a convalescent home or have a nurse in attendance at home. This benefit also needs to be approved by our Medical Director. This benefit doesn't cover spas, cure centres, health resorts, palliative care or long-term care (see 'Palliative care' and 'Long-term care' definitions).

O

Obesity is diagnosed when a person has a body mass index (BMI) of over 30 (you can find a BMI calculator at: www.allianzcare.com/members).

Occupational therapy is treatment that helps you develop skills needed for daily living and interactions with other people and the environment. These refer to:

- Fine and gross motor skills (how you perform small, precise tasks and whole-body movement).
- Sensory integration (how the brain organises a response to your senses).
- Coordination, balance and other skills such as dressing, eating and grooming.

Out-patient occupational therapy requires pre-approval. We will need a progress report after every 20 sessions.

Oncology refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis. We also cover the cost of an external prosthetic device for cosmetic purposes, for example a wig for hair loss or a prosthetic bra after breast cancer treatment.

Oral and maxillofacial surgical procedures refers to surgical treatment on the mouth, jaws, face or neck performed in a hospital by an oral and maxillofacial surgeon for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours.

Unless you hold a Dental Plan, we do not cover the following procedures even if they are performed by an oral and maxillofacial surgeon:

- Surgical removal of impacted teeth
- Surgical removal of cysts
- Orthognathic surgeries for the correction of malocclusion

Organ transplant refers to the following organ or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea. We do not reimburse the costs of acquiring organs.

Orthodontics is the use of devices to correct malocclusion (misalignment of your teeth and bite). We only cover orthodontic treatment that meets the medical necessity criteria described below. As the criteria is very technical, please contact us before starting treatment so we can verify if your treatment meets the criteria.

Medical necessity criteria:

a) Increased overjet > 6mm but <= 9 mm
b) Reverse overjet > 3.5 mm with no masticatory or speech difficulties
c) Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position
d) Severe displacements of teeth > 4
e) Extreme lateral or anterior open bites > 4 mm
f) Increased and complete overbite with gingival or palatal trauma
g) Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis
h) Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments
i) Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties
j) Partially erupted teeth, tipped and impacted against adjacent teeth
k) Existing supernumerary teeth

You will need to send us some supporting information to show that your treatment is medically necessary and therefore covered by your plan. The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.
- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).
- Any other document we may need to assess the claim.

We will only cover the cost of standard metallic braces and/or standard removable appliances. However, we'll cover cosmetic appliances such as lingual braces and invisible aligners up to the cost of metallic braces, subject to the 'Orthodontic treatment' benefit limit.

Orthomolecular treatment refers to alternative treatment that aims to restore the individual biochemical balance through supplements. It uses natural substances such as vitamins, minerals, enzymes and hormones.

Out-patient dental treatment is a benefit that specifically covers out-patient dental treatment required as follow-up to an in-patient stay for accidental damage to natural teeth. Cover is provided when the out-patient dental treatment is required in the 90 days following discharge from the related in-patient treatment. Cover includes the costs to supply and fit dental implants.

Out-patient surgery is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require you to stay overnight out of medical necessity.

Out-patient treatment refers to treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require you to be admitted to hospital.

P

Palliative care refers to ongoing treatment that aims to alleviate the physical/psychological suffering associated with progressive, incurable illness and to maintain quality of life. It includes in-patient, day-care and out-patient treatment following the diagnosis of a terminal condition. We will pay for physical care, psychological care, hospital or hospice accommodation, nursing care and prescription drugs.

Periodontics refers to dental treatment related to gum disease.

Post-hospitalization treatment refers to out-patient treatment required in the 90 days following discharge from an in-patient or day-care treatment for the same acute medical condition. This benefit covers medical practitioners' fees, specialists' fees, out-patient surgery, prescribed drugs and dressings, MRI, PET and CT scans, X-rays, pathology and other diagnostic tests and procedures.

Post-hospitalization physiotherapy refers to physiotherapy treatment required in the 90 days following discharge from an in-patient or day-care treatment of less than 3 days in duration.

Post-natal care refers to the routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-existing conditions are medical conditions for which one or more symptoms presented at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment. We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants would have known about it.

The following terms about pre-existing conditions apply if your Insurance Certificate shows that your underwriting terms are Full Medical Underwriting or CPME/CTT previously FMU:

Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you completed the application form and the later of the following:

- The date we issued your Insurance Certificate or
- The start date of your policy

Such pre-existing conditions will also be subject to full medical underwriting and if they are not disclosed, they will not be covered. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

The following terms about pre-existing conditions apply if your Insurance Certificate shows that your underwriting terms are moratorium or CPME/CTT previously MORI:

Your claim will not be paid if it's relating to a pre-existing medical condition, should one or more of the following have applied within the 24-month period before your start date (or the date shown in your Insurance Certificate:

- It could be reasonably foreseen that the medical condition would occur after your start date.
- The condition clearly showed itself.
- You had signs or symptoms of the condition.
- You asked for advice about the condition.
- You received treatment for the condition, or
- To the best of your knowledge, you were aware you had the condition.

Once you've completed a continuous 24-month period after your date of joining we may cover your pre-existing medical condition provided you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

Pregnancy refers to the period of time when you are expecting a baby, from the date of the first diagnosis until delivery.

Pre-natal care includes common screening and follow-up tests required during pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and, if directly linked to an eligible amniocentesis, DNA-analysis.

Pre-operative tests refers to out-patient pre-operative tests carried out in the 72 hours before in-patient or day-care treatment covered under your plan.

Prescribed drugs and dressings refers to drugs when prescribed by a doctor to:

- Treat a confirmed diagnosis or medical condition
- Compensate a lack of vital bodily substances

Prescribed drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by the pharmaceutical regulator in the country where you use the prescription. Even if you can legally buy a medication without a doctor's prescription in that country, you must get a prescription for these costs to be covered. You can claim for a supply of up to 3 months from the prescription date, subject to length of time remaining on the policy.

Prescribed glasses and contact lenses including eye examination refers to cover for a routine eye examination carried out by an optometrist or ophthalmologist (one check-up per Insurance Year) and for lenses and glasses to correct vision.

Prescribed medical aids refers to any device which is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.
- Hearing and speaking aids such as an electronic larynx.
- Medically graduated compression stockings.
- Long-term wound aids such as dressings and stoma supplies.

We do not cover costs for medical aids that form part of palliative care or long-term care (see the definitions of 'Palliative care' and 'Long-term care').

Prescribed physiotherapy refers to treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by the doctor who referred you. If you need further sessions, you must send us a new progress report after every set of 12 sessions, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Preventative surgery refers to prophylactic mastectomy or prophylactic oophorectomy. We will pay for preventative surgery when you:

- Have a direct family history of a disease which is part of a hereditary cancer syndrome (for example, breast cancer or ovarian cancer) and
- Genetic testing has established the presence of a hereditary cancer syndrome.

Preventive treatment refers to treatment you receive without any clinical symptoms being present at the time of treatment (e.g. the removal of a pre-cancerous growth). This benefit is covered when the 'Preventive treatment' benefit is listed in your Table of Benefits.

Principal country of residence is the country where you and your dependants (if applicable) live for more than six months of the year.

Psychiatry and psychotherapy refers to the treatment of mental, behavioural and personality disorders, including autism spectrum and eating disorder. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant and the treatment medically necessary.

All day-care or in-patient admissions must include prescription medication related to the condition. Out-patient psychotherapy treatment (where covered) requires referral by a doctor and is limited for 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

Counselling is available through our Employee Assistance Programme (EAP) and refers to short-term, solution-focused interventions, and typically deals with current issues that are easily resolved on the conscious level. This is not meant for longer-term situations or the treatment of clinical disorders. EAP can help you and your immediate family deal with challenging situations that may arise in life, such as stress, anxiety, bereavement, workplace challenges, relationship issues, cross-cultural transition, coping with isolation and loneliness. For more information see the 'Employee Assistance Programme (EAP)' section of this guide.

R

Reasonable and customary refers to treatment costs that are usual within the country of treatment. We will only reimburse the cost of medical providers where their charges are reasonable and customary and in accordance with standard and generally accepted medical procedures.

Reconstructive surgery refers to treatment costs to restore natural function or appearance after a disfiguring accident or surgery for cancer. Cover is only provided if the accident or initial surgery occurs during your period of cover.

Rehabilitation is treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery. Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment. Cover is only provided under this benefit if you've received in-patient treatment for three or more consecutive days/nights for the same medical condition.

Related medical conditions refers to any injury, illness or disease that, based on medical advice or general advice, we determine is the result of any one or more other medical conditions.

Repatriation of mortal remains is the transportation of the insured deceased remains from the principal country of residence to the country of burial. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if the cremation is required for legal purposes. We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits.

Routine dental treatment includes an annual check up, simple fillings related to cavities or decay and root canal treatment.

Routine maternity refers to medically necessary costs incurred during pregnancy and childbirth. This includes hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, all babies born by surrogacy and multiple birth babies born as a result of medically assisted reproduction). We do not cover costs of complications of pregnancy and childbirth under the 'Routine maternity' benefit. Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit.

In case of home deliveries, we will pay up to the amount specified in the Table of Benefits if your plan includes the 'Home delivery' benefit.

S

Sleep apnoea is a sleep disorder characterised by pauses in breathing or periods of shallow breathing during sleep. If this benefit is indicated in your Table of Benefits, we will provide cover for the medical necessary treatment and diagnostic procedures related to a confirmed or suspected sleep apnoea diagnosis. The costs which are covered under this benefit include professional fees, a medical necessary sleep study, other necessary diagnostic tests, medical aids and drugs, up to the limits indicated on your Table of Benefits. Please note that proof of medical necessity is required.

Specialist is a licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine.

Specialist fees refers to non-surgical treatment performed or administered by a licensed doctor. This benefit does not include cover for psychiatrist, psychologist fees or any treatment that is already covered by another benefit under your Table of Benefits. We don't cover specialist treatment that is excluded under your policy.

Speech therapy refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments. This includes conditions such as nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Start date is the date when you first enrolled, or re-enrolled if there is a break in your cover.

Surgical appliances and materials are those required for surgeries. They include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

T

Therapist refers to a chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the laws of the country in which treatment takes place.

Travel costs of insured family members in the event of an evacuation/repatriation refers to the reasonable transportation costs of all insured family members of the evacuated or repatriated person, including minors who might otherwise be left unattended. If all family members can't travel in the same vehicle with the evacuated/repatriated person, we will pay for their round-trip transport at economy rates.

The "Travel costs of insured family members in the event of a repatriation" benefit is covered if you have a repatriation plan. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured family members in the event of the repatriation of mortal remains refers to reasonable transportation costs of any insured family members who had been living abroad with the insured person who died, to travel to the country of burial of the deceased. Reasonable transportation costs are considered to be round trip transport costs at economy rates. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured members to be with a family member who is at peril of death or who has died refers to the reasonable transportation costs of insured family members to be with a first-degree relative who is at peril of death or who has died (up to the amount specified in your Table of Benefits). In the case of a deceased relative, travel must commence within 6 weeks of their date of death. Reasonable transportation costs are considered to be round trip transport costs at economy rates. A first-degree relative is a spouse, parent, brother, sister or child, including adopted children, fostered children or step-children. When claiming, please include copies of the travel tickets and the death certificate or a doctor's certificate supporting the reason for travel. Cover does not include hotel accommodation or other related expenses.

Treatment refers to a medical procedure needed to cure or relieve illness or injury.

Treatment of autism spectrum disorder refers to a range of therapies to improve the skills of an insured person with autism. This includes specialist medical treatment and accredited behavioural programmes. Treatment is covered as part of the 'Psychiatry and psychotherapy' benefit of your Out-patient Plan, if you have one. Check your Table of Benefit for any limits that may apply. We don't cover admissions, stays or day care treatment at specialised educational facilities.

Treatment of eating disorders refers to a combination of psychotherapies, including cognitive behavioural therapy, medical monitoring, prescribed medication and nutritional counselling to treat anorexia nervosa, bulimia nervosa and binge-eating disorder.

All day-care or in-patient admissions must include prescription medication related to the condition.

Out-patient therapy (where covered) requires referral by a doctor and is limited for 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

V

Vaccinations refer to:

- All basic immunisations and booster injections that are required by law in the country in which they are administered.
- Vaccination against Covid-19*, where this is not offered for free or only partially sponsored by the government in your country of residence.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

We cover the cost of consultation for administering the vaccine and the cost of the drug.

*We cover any Covid-19 vaccine when:

- The vaccine has completed the necessary clinical development process, including all pre-licensure vaccine clinical trials (phase I, II and III) which demonstrate its efficacy and safety.
- The vaccine has completed the multi-step approval process for the relevant regulating authority and is approved for use in the jurisdiction where you require it.
- The vaccine is not offered for free or only partially sponsored by the government of the country in which you reside.

We cover the reasonable and customary cost of the Covid-19 vaccine, including the administration of the injection, in line with local public health policies related to the allocation of vaccines. We do not pay towards the travel cost if you decide to travel to a different country from where you normally reside in order to get the vaccination. Please note that cover is not intended to give you priority access to vaccines.

Video consultation services provide direct access to a doctor via a telecommunication platform. This benefit covers the costs of video consultations, as indicated in your Table of Benefits and offers medical advice, diagnosis and issuance of a prescription, if needed, for non-urgent medical care. Access to teleconsultation services and prescriptions will depend on your geographical location and local country regulations. You can make an appointment to speak to a medical practitioner in English, subject to availability. Some third party providers may offer additional core languages. Cost of medicines are not included, but delivery of medicine or referrals may or may not be included under this benefit, even when prescribed or recommended during the video consultation.

W

Waiting period is a period of time that begins on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your Table of Benefits shows which benefits are subject to waiting periods.

We/Our/Us is Allianz Care.

Y

You/Your refers to the person working for the company and any dependants named on the Insurance Certificate.

Exclusions

Although we cover most medically necessary treatment, we do not cover the following expenses unless indicated otherwise in the Table of Benefits or in any written policy endorsement.

ACQUISITION OF AN ORGAN

Expenses for the acquisition of an organ such as, but no limited to donor search, typing, harvesting, transport and administration costs.

CHEMICAL CONTAMINATION AND RADIOACTIVITY

Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material, including the combustion of nuclear fuel.

COMPLEMENTARY TREATMENT

Complementary treatment, with the exception of those treatments shown in the Table of Benefits.

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN

Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

CONSULTATIONS PERFORMED BY YOU OR A FAMILY MEMBER

Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

DENTAL VENEERS

Dental veneers and related procedures.

DEVELOPMENTAL DELAY

Delay in cognitive or physical development, unless a child has not achieved the developmental milestones expected for a child of that age. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified medical professionals and documented as a delay in development of at least 12 months.

DRUG ADDICTION OR ALCOHOLISM

Care and/or treatment of drug addiction or alcoholism (including detoxification programmes and treatments to stop smoking), death associated with drug addiction or alcoholism, or the treatment of any condition that in our reasonable opinion is related to, or a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY

Any form of treatment or drug therapy which in our reasonable opinion is experimental or unproven, based on generally accepted medical practice.

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE

Treatment required as a result of failure to seek or follow medical advice.

FAMILY THERAPY AND COUNSELLING

Costs in respect of a family therapist or counsellor for out-patient psychotherapy treatment.

FEES FOR THE COMPLETION OF A CLAIM FORM

Doctor's fees for the completion of a Claim Form or other administration charges.

GENETIC TESTING

Genetic testing, except:

a) Where specific genetic tests are included within your plan.
b) Where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
c) Where testing for genetic receptor of tumours is covered.

HOME VISITS

Home visits, unless they are necessary after the sudden onset of an acute illness that leaves you incapable of visiting your doctor or therapist.

INFERTILITY TREATMENT

Infertility treatment including medically assisted reproduction or treatment for any medical problems arising from it, unless you have a specific benefit for infertility treatment or have the required out-patient benefits that would cover non-invasive investigations into the cause of infertility (such as 'Medical practitioner' fees, 'Specialist fees' and 'Diagnostic' tests).

INJURIES CAUSED BY PROFESSIONAL SPORTS

Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES

Care and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

LOSS OF HAIR AND HAIR REPLACEMENT

Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

MEDICAL ERROR

Treatment required as a result of medical error.

MORTAL REMAINS

The purchase of a burial plot, or funeral costs, including, but not limited to, flowers and the funeral director's fees.

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.

ORTHOMOLECULAR TREATMENT

Please refer to the definition of "Orthomolecular treatment".

PARTICIPATION IN WAR OR CRIMINAL ACTS

Death from or treatment for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:

- War
- Riots
- Civil disturbances
- Terrorism
- Criminal acts
- Illegal acts
- Acts against any foreign hostility

PLASTIC SURGERY

Treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes, and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or surgery occurs during your period of cover.

PRE- AND POST-NATAL

Pre- and post-natal classes.

PRE-EXISTING CONDITIONS (APPLICABLE TO POLICIES WITH FULL MEDICAL UNDERWRITING OR CPME/CTT PREVIOUSLY FMU)

Pre-existing conditions (including pre-existing chronic conditions) when:

- Indicated on a Special Conditions Form that we issue before your policy starts
- Conditions were not disclosed on the application form
- Conditions arise between completing the application form and the later of the following:
  - The date we issue your Insurance Certificate or
  - The start date of your policy

Such conditions will also be subject to medical underwriting and if not disclosed, will not be covered.

PRE-EXISTING CONDITIONS (APPLICABLE TO POLICIES WITH MORATORIUM OR CPME/CTT PREVIOUSLY MORI)

Pre-existing medical conditions when one or more of the following have applied within the 24-month period before your date of joining (or the date shown in your Insurance Certificate):

- It could be reasonably foreseen that the medical condition would occur after your start date.
- The condition clearly showed itself.
- You had signs or symptoms of the condition.
- You asked for advice about the condition.
- You received treatment for the condition.
- To the best of your knowledge, you were aware you had the condition.

Once you've completed a continuous 24-month period after your date of joining your pre-existing medical condition may be covered provided you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

PRODUCTS PURCHASED WITHOUT A PRESCRIPTION

Products that are purchased without a doctor's prescription.

SEX CHANGE

Sex change related operations and related treatments such as:

- Blepharoplasty
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Face/forehead lift
- Facial bone reduction (osteoplasty)
- Hair removal/hair transplantation
- Jaw reduction
- Laryngoplasty
- Rhinoplasty
- Skin resurfacing (e.g., dermabrasion, chemical peels)
- Thyroid reduction chondroplasty
- Neck tightening
- Lip enhancement
- Botox and filler injections

SLEEP DISORDERS

Treatment of sleep disorders, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism.

SPEECH THERAPY

Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

STAYS IN A CURE CENTRE

Stays in a cure centre, bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed.

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION

Investigations into, treatment of and complications arising from:

- Sterilisation.
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery).
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons). The only exception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

SUBSTANCES, PERSONAL PRODUCTS AND DIETARY SUPPLEMENTS

Substances, personal products and dietary supplements including vitamins and minerals (except during pregnancy to treat diagnosed vitamin deficiency syndromes), mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, cosmetic products, sanitiser, gloves, masks, visors, thermometers, children's food, baby supplies and infant formula given orally. These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

SURROGACY

Treatment directly related to surrogacy whether you are acting as a surrogate, or are the intended parent.

TERMINATION OF PREGNANCY

Termination of pregnancy, except where the life of the pregnant woman is in danger.

TRAVEL COSTS

Travel costs to and from medical facilities (including parking costs) for treatment, except when covered under 'Local ambulance', 'Medical evacuation' and 'Medical repatriation' benefits.

TREATMENT IN THE USA IN THE FOLLOWING CASES

Treatment in the USA if we believe that cover was taken out with the purpose of travelling to the USA to get treatment for a condition or symptoms you were aware of:

- before being insured with us
- before having the USA in your region of cover

If we paid any claims in these circumstances, we reserve the right to seek reimbursement from you.

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER

Treatment outside the geographical area of cover unless for emergencies or authorised by us.

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS

Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

TUMOUR MARKER TESTING

Tumour marker testing, unless you have previously been diagnosed with the specific cancer in question, in which case cover is provided under the 'Oncology' benefit.

VESSEL AT SEA

Medical evacuation/repatriation from a vessel at sea to a medical facility on land.

BENEFITS THAT ARE NOT IN YOUR TABLE OF BENEFITS

The following benefits or any adverse consequences or complications relating to them, unless otherwise indicated in your Table of Benefits:

- Complications of pregnancy and childbirth.
- Congenital conditions.
- Dental treatment, dental surgery, periodontics, orthodontics, dental implants and dental prostheses. The only exception is oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- Dietician fees.
- Emergency dental treatment.
- Expenses for one person accompanying an evacuated/repatriated person.
- Health and wellbeing checks including screening for the early detection of illness or disease.
- HIV/AIDs treatment.
- Home delivery.
- Homeopathy, Chinese herbal medicine, acupuncture and ayurvedic treatment.
- Hormone replacement therapy.
- Infertility treatment.
- In-patient psychiatry and psychotherapy treatment.
- Laser eye treatment.
- Medical evacuation in the event of non-emergency treatment.
- Medical repatriation.
- Out-patient psychiatry and psychotherapy treatment.
- Out-patient treatment.

- Palliative care.
- Prescribed glasses and contact lenses including eye examination.
- Prescribed medical aids.
- Preventative surgery and treatment.
- Rehabilitation treatment.
- Repatriation of mortal remains or burial expenses.
- Routine maternity.
- Travel costs of insured family members in the event of an evacuation/repatriation.
- Travel costs of insured family members in the event of the repatriation of mortal remains.
- Travel costs of insured members to be with a family member who is at peril of death or who has died.
- Vaccinations.

ACCIDENTAL DEATH BENEFIT

Accidental death benefit, if the death of an insured person has been caused directly or indirectly by:

- Active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.
- Intentionally caused diseases or self-inflicted injuries, including suicide, within one year of the enrolment date of the policy.
- Active participation in underground or underwater activity such as underground mining or deep-sea diving.
- Above-water activity (such as on oil platforms or oil rigs) and aerial activity, unless specifically covered under the Company Agreement.
- Chemical or biological contamination, radioactivity or any nuclear material contamination, including the combustion of nuclear fuel.
- Passive war risk:
  - Being in a country where the British government has recommended that their citizens leave (this condition will apply regardless of the insured person's nationality) and has advised against "all travel" to that location or
  - Travelling to or staying, for more than 28 days per stay, in a country or an area where the British government advises "against all but essential travel".

  The passive war risk exclusion applies regardless of whether the claim arises directly or indirectly as a consequence of war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.
- Being under the influence of drugs or alcohol.
- Death that takes place more than 365 days after the occurrence of the accident.

- **Deliberate exposure to danger, except in an attempt to save human life.**
- **Intentional inhalation of gas or intentional ingestion of poisons or legally prohibited drugs.**
- **Flying in an aircraft, including helicopters, unless the insured person is a passenger and the pilot is legally licensed, or is a military pilot and has filed a scheduled flight plan when required by local regulations.**
- **Active participation in extreme or professional sports including, but not limited to:**
  - **Mountain sports such as abseiling, mountaineering and racing of any kind (except for racing on foot).**
  - **Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.**
  - **Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.**
  - **Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.**
  - **Car and motorcycle sports such as motorcycle riding and quad biking.**
  - **Combative sports.**
  - **Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.**
  - **Various other sports such as bungee jumping.**

Talk to us, we love to help!

If you have any queries, please do not hesitate to contact us:

24/7 Helpline for general enquiries and emergency assistance

8000 155 (calling toll-free from within Qatar)
+974 4031 8444 (calling from within or outside of Qatar)

Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes. Please note that only the policyholder (or an appointed representative) or the Group Scheme Manager can make changes to the policy. Security questions will be asked of all callers to verify identity.

Email: client.services@allianzworldwidecare.com

Fax: +974 4031 8484

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