Regional Cover
Health Perfect Series
Health Perfect 4 - Gulf

Important information about your plan

The table of benefits included here is to be read in conjunction with your membership handbook which sets out the contractual agreement and rules of your scheme.

1. How claims affect your benefit limits.

Benefit values are reduced each time you claim only by the net amount (Invoice value less any deductible, excess, co-insurance or ineligible treatment) we have actually paid. In applying deductibles and co-insurance (the percentage of eligible benefit payable by the member) we will subtract the deductible first and then apply the co-insurance to the balance of eligible benefit remaining.

Please note: when a benefit is shown as 'covered up to the policy limit' all related sub-limits such as those applicable to pre-existing conditions will apply in any event. Full policy terms and conditions apply at all times.

Reasonable and Customary Charges.

All benefits and services submitted for reimbursement of claims shall be evaluated based on the Reasonable and Customary Rates. AXA will pay the actual cost incurred or the Reasonable and Customary Rate against the service whichever is less and the level of reimbursement shall be decided based on the Network offered.

The following conditions would apply-

(i) Co-insurance/Deductible as applicable under the plan would be deducted wherever applicable from the eligible amount prior to reimbursement.

(ii) Pharmacy will be paid on actual as per terms and conditions of the Policy.

(iii) Benefits/Services not included in the list of Reasonable and Customary rates shall be dealt with on a case to case basis.

(iv) The actual amount payable shall be based on the itemized bill submitted and the codes used per service by the Service Provider. Where itemized bill is not submitted and where service provided are without defined codes they would be assessed on a case to case basis.

(v) Reasonable and Customary rates factor shall be based on the country where Policy is issued and shall be applicable for treatments taken within the G.C.C.

(vi) Where no network exists or the treatment is not available within the network providers (for treatment in countries where Reasonable and Customary rates are not available), AXA Insurance will base the calculation on the average cost of the treatment in that area or country; or the network in the principle country of residence.

(vii) Special arrangements if any would reflect in the Table of Benefits issued by AXA.

Why you must contact us before receiving treatment.

We require you to contact us before receiving any planned admission and some major out-patient treatment. This allows us to help you in a number of ways: by managing your admission and billing, by confirming to you and whoever is giving you treatment that your claim will be eligible, at what cost and for how long treatment is approved. If you do not contact us it is possible that you will have to pay for all or part of your treatment.

Why you must identify yourself as an AXA member.

Prior to receiving treatment anywhere you must identify yourself and your eligibility for discounts by showing your AXA medical ID Card, together with a recognized official form of identification, such as a passport, to any provider to show that you are an insured member of an AXA insurance policy.

Failure to ensure that the provider recognizes your entitlement to our discounted services may result in the member being required to pay any difference between the invoice value and our negotiated price.

Please note: that AXA Insurance reserves the right to recover from the member any ineligible expenses it has incurred on behalf of that insured member under one of its policies.

What you're covered for: Please note: the benefits shown are for each member each year unless otherwise specified		
2. Area of cover	G.C.C.: Saudi Arabia, Kuwait, Bahrain, Qatar, UAE and Oman, plus Jordan, Iran, Lebanon, Syria, Egypt, Tunisia, Morocco, Algeria, India, Pakistan, Sri Lanka, Bangladesh, Korea, the Philippines, Indonesia, Nepal & Bhutan	We will pay up to the maximum shown for each member each policy year. All benefits paid during the policy period will count against this yearly maximum.
3. Yearly maximum	AED/QAR 2,500,000, OMR/BHD 250,000	
4. Outside area of cover	Worldwide, Up to AED/QAR 250,000, OMR/BHD 25,000	This is to cover emergency treatment, or treatment of a medical condition which arises suddenly whilst outside the member's area of cover. We will, in consultation with the treating practitioner, retain the right to determine what constitutes 'emergency' treatment. This benefit does not provide cover for treatment for any condition if you have travelled outside your area of cover to get treatment (whether or not that was the only reason) or for any treatment which was, or may have reasonably been known about, before travel commenced. Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth.
In-patient and daycare Treatment		
5. By in-patient treatment, we mean treatment at a hospital where the member has to stay in a hospital bed for one or more nights. By Daycare treatment, we mean treatment at a hospital, daycare unit, or out-patient clinic where the member requires a procedure, eligible for benefit, necessitating admission to a hospital bed but not requiring an overnight stay. Subject to the limits shown for your plan you are covered for hospital charges incurred for eligible treatment given between admission and discharge such as: ▪ charges for accommodation ▪ diagnostic procedures ▪ operating theatre charges ▪ nursing care, drugs and dressings ▪ surgical appliances used by the medical practitioner during surgery except external prosthesis or appliances ▪ surgeon's and anaesthetist's charges including pre- and post- operative consultations ▪ intensive care unit charges ▪ consultations and physiotherapy while admitted for treatment of a medical condition and when such treatment directly relates to it ▪ radiotherapy and chemotherapy ▪ computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques. Please note: All non-emergency admissions require our written pre-approval before admission. The approval we give to the provider for eligible to be paid for the proposed treatment and the anticipated length of stay.		
6. Daily accommodation charges	Included	By "accommodation", we mean a private, single-bedded, room with its own bathroom.
7. Parent accommodation up to (per night)	AED/QAR 1,000, OMR/BHD 100 per night	We will pay when the child member is under 18 years old and treatment is received within your area of cover. This is paid from the child's benefit. Benefit is payable for a maximum of 28 days in a year.
9. Cash benefit	AED 1,000, OMR/BHD 100 per night	This is payable for in-patient treatment only when the member receives treatment, within the area of cover, absolutely free of charge. No other benefit will be payable in respect of the period for which the cash benefit has been claimed. *Not applicable for Qatar Policies.
10. In-patient Direct Billing	Included	All non-emergency in-patient treatment must be approved by us, in writing, prior to admission. You can take advantage of direct billing facilities for eligible in-patient care within our global network. Please note: Prior to receiving treatment anywhere you must identify yourself and your eligibility for discounts by showing your AXA medical ID Card, together with a recognized official form of identification, such as a passport, to any provider to show that you are an insured member of an AXA insurance policy. Failure to ensure that the provider recognizes your entitlement to our discounted services may result in the member being required to pay any difference between the invoice value and our negotiated price. Please note that AXA Insurance reserves the right to recover from the member any ineligible expenses it has incurred on behalf of that insured member under one of its policies.
11. Applicable in-patient direct billing network	STAR & International Directory of Hospitals*	

Out-patient Treatment		
12. Out-patient treatment is a treatment given by a medical practitioner at an out-patient clinic, a medical practitioner's consulting room or in a hospital where the member is not admitted to a bed. You are covered, subject to the limits shown, for: ■ medical practitioner charges for consultations ■ diagnostic procedures ■ prescriptions (note: any prescribed drug or other medication required for more than 30 days must be approved by us) ■ physiotherapy received as out-patient (this is subject to our written pre-approval) ■ CT and MRI, PET and Gait Scans and internal diagnostics received as an out-patient (this is subject to our written pre-approval) ■ radiotherapy and chemotherapy received as an out-patient (this is subject to our written pre-approval) ■ surgical procedures received as an out-patient (this is subject to our written pre-approval).		
13. GP and specialist consultation charges	Included	A consultation is a visit to any medical practitioner for the treatment of an eligible medical condition. Please note: Second opinions for the same condition; Pre-approval is not required for Health Perfect and Secure Plans 1, 2 and 3. Written approval for Health Perfect and Secure Plans 4, 5, 6 and 7 is required. Thereafter subsequent opinions and referrals for the same condition, written approval is required for all Plans.
14. Courses of physiotherapy up to	Included	Such treatment must be pre-approved by us in writing and be given by a qualified practitioner who is recognized by us and registered to practice this where the treatment is given. By 'course' we mean a maximum of five sessions within a period of five consecutive weeks. Treatment given by a physiotherapist, chiropractor, osteopath must be under the medical supervision of a medical practitioner. Medical supervision means that the reason for referral has been initiated by the medical practitioner who has defined a diagnosis. There must be a clear treatment program from the physiotherapist, chiropractor, osteopath with an end point and expected outcome. Any further treatment needed after the approved limits of that treatment program have been reached will require review and further referral by the supervising medical practitioner and approval by us. The supervising medical practitioner takes overall clinical responsibility for the member including diagnosis and prescribed medicines. Claim forms must be completed by the medical practitioner, as physiotherapists, chiropractors and osteopaths are not authorized by us to do so.
15. Complementary therapy up to Includes courses of chiropractic treatment and osteopathy	AED/QAR 3,000, OMR/ BHD 300 in aggregate	
16. Alternative treatment		Alternative treatment refers to non-conventional medicine practiced by practitioners who do not usually hold a degree in medicine from a recognized school of medicine but hold a degree in other forms of medicine. While this plan is primarily designed to cover proven and conventional treatment we recognize that some other forms of treatment have demonstrated curative properties. We will pay for alternative treatment up to the limit shown for this benefit. Such treatment must be given by a qualified practitioner who is recognized by us and registered to practice where the treatment is given. We recommend that you obtain a non contra-indication for the use of alternative treatment from your treating medical practitioner as we will not pay for any complications arising from such treatment in excess of the limit shown for this benefit.
17. Per visit deductible (excess) applicable to all out-patient claims This applies before any co-insurance.	AED/QAR 50, OMR/BHD 5*	This is the amount of the eligible expenses claimed that the member will have to bear. The amount will be collected by whoever provides your treatment (for direct billing) or deducted from any reimbursement made to you by us. The amount shown applies to each and every out-patient consultation or treatment received as an out-patient. Deductibles always apply to each member even when consultation or treatment are received by more than one at the same time.

18. Out-patient direct billing (only available within the G.C.C.)	Included	Out-patient direct billing is available only in the network shown for your plan within the G.C.C.
19. Applicable out-patient direct billing network	STAR*	Please refer to the list applicable to your plan.
Other Benefits		
These are additional features of your plan. Please note that all deductibles, limitations and terms apply to these benefits exactly as for the main in-patient, daycare and out-patient benefits depending on whether treatment is received as an out-patient, in-patient or daycare patient.		
20. Health screen up to	AED/QAR 500, OMR/BHD 50	The limit shown for your plan includes the cost of any eligible consultation, diagnostic procedures and/or assessment (such as, but not limited to, mammogram, pap smear, prostate and colon cancer screening) associated with the screening process. Any eligible consultation, diagnostic procedures and/or assessment costs not directly related to the treatment of a medical condition will be taken from this benefit.
21. Pre-existing conditions (including pre-existing chronic conditions) up to	AED/QAR 2,500, OMR/BHD 250	Such treatment must be pre-approved by us in writing. This benefit provides cover for pre-existing conditions whether chronic or not. All treatment in respect of such conditions, including any acute phase, will be taken from this benefit up to the level shown for your plan. All eligible conditions that existed or for which there were symptoms before the inception of the policy will be paid for from this benefit and subject to the limit shown. All such conditions must, in good faith, have been notified to AXA Insurance in writing. Please note that the treatment of the acute phase of any pre-existing condition, whether chronic or not, will be paid for out of this benefit and the limit of this benefit will apply in any event. Treatment of conditions which are, in our opinion, related to an eligible preexisting condition will also be subject to the limit of this benefit. AXA Insurance reserves the right to refuse to pay benefit for any such condition which was not declared on a member's application form.
22. Non pre-existing chronic conditions, arising and diagnosed after policy inception, up to	AED/QAR 25,000, OMR/BHD 2,500	Such treatment must be pre-approved by us in writing. This benefit provides cover for chronic conditions where the condition arises and the initial diagnosis of the chronic condition is made after the inception of the policy. This benefit includes cover for routine maintenance of chronic conditions. The acute phase of any such chronic condition will be taken from the main in- and out-patient benefits of your plan and will not erode this benefit.
23. Oral and maxillofacial surgery	Included	Such treatment must be pre-approved by us in writing. A list of surgical procedures covered by this benefit is available from us on request. Please note: this benefit does not cover routine dental care.
24. Nursing at home	Included	This benefit pays for the services of a qualified and registered nurse, recognized by us. Benefit is payable for the medically necessary provision of continuing care, at the member's home, immediately following eligible in-patient treatment covered under your plan. There must be a clear treatment program, agreed by us in advance with the treating medical practitioner, with a definite end point and expected outcome. Benefit is payable for a maximum of 28 days in a year. Please note: this benefit requires our written prior approval.

Only for Qatar (Plan 4): Applicable In-Patient direct billing network is Star Plus & International Directory of Hospitals, Applicable Out-Patient direct billing network is Star Plus. Applicable deductible is (50 QAR) on all Out-Patient claims, in addition to 20% co-insurance for STAR PLUS network clinics and hospitals.

Other Benefits - continued		
25. Ambulance transport	Included	This is to pay for a road ambulance for emergency treatment to or between hospitals, or when the medical practitioner says it is medically essential.
26. International Emergency Medical Assistance	Included	Emergency evacuation is covered in full when you are away from your principal country of residence and may apply if appropriate emergency treatment is not available in your principal country of residence. Evacuation, when medically necessary, will always be to the nearest place where appropriate treatment can be given. A member evacuated in an emergency will subsequently be returned to their principal country of residence. Repatriation of mortal remains if a member is abroad is included – this may be to the principal country of residence or to the home country. Please note that entitlement to the evacuation service does not mean that the member's treatment following evacuation or repatriation will be eligible for benefit. Any such treatment will be subject to the terms and conditions of the member's plan. Please refer to the IEMA leaflet for full details.
27. Psychiatric treatment up to	AED/QAR 5,000, OMR/BHD 500 (A coinsurance of 30% applies to this benefit.)	The limit shown applies to in-patient, daycare and out-patient treatment in aggregate. Any deductible applies in addition to the co-insurance for all out-patient treatment under this benefit. No benefit is payable for the services of a psychologist unless a treatment received is under the supervision of psychiatrist and both practitioners are recognized by us. Please note: this benefit requires our written prior approval.
28. Accidental damage to teeth	Included	Under accidental damage to teeth, we will pay for treatment required immediately (within seven days) following accidental damage to natural teeth caused by external trauma when the treatment is given by a medical practitioner to relieve pain and restore function. This is for the initial treatment only; it does not include any follow-up treatment. Please note: There is no cover for treatment required as a result of the consumption of food or drink or any foreign bodies contained in such food or drink nor for the replacement of any dental prostheses such as but not limited to dental crowns, caps or veneers. This benefit does not cover routine dental care. This benefit requires our written prior approval.

Other Benefits - continued		
29. Pre and post-natal complications	Included - 12 month waiting period	Benefit only becomes available and eligible claims payable for expenses incurred after the member has been continuously covered under their chosen plan for 12 consecutive months and has effected the annual renewal of that plan for the coming policy year. This benefit will, subject to the limitations and exclusions of this policy, cover eligible treatment of both the mother and any unborn child up to the moment of delivery. Thereafter cover will be restricted to eligible treatment for the mother alone. Any newborn infant may be added to the mother's policy and enjoy cover commencing at the time of birth provided we are requested to add that infant to the mother's policy within 30 days from the time of birth and the parental cover is in force at the time of delivery. If the mother is not covered by us at the time of delivery a newborn baby may only be added to the father's policy and be eligible for benefit after final discharge of the child into parental care. This benefit does not cover the costs of delivery of any child whether such delivery is normal, by caesarean section or by any other means. Where a waiting period applies prior to any upgrade in cover this benefit, after the upgrade, will be restricted to the terms applicable to the original plan until the member has been covered under the upgraded plan for a period of not less than 12 consecutive months and has effected the annual renewal of the upgraded plan.
30. Normal Pregnancy, Childbirth (Delivery) and medically necessary Caesarean section up to	AED/QAR 25,000, OMR/BHD 2,500 12 month waiting period	Such treatment must be pre-approved by us in writing. Benefits only become available and eligible claims payable for expenses incurred after the member has been continuously covered under their chosen plan for 12 consecutive months and has effected the annual renewal of that plan for the coming policy year. This benefit is only available for women over the age of 18 years and only once per pregnancy per policy year per female member. If a pregnancy, which is eligible for benefit, falls across the policy anniversary, the member will be eligible for only one application of this benefit. The benefit will be deemed to have been used in the policy year in which the first pre-natal consultation was undertaken and provided the policy, including this benefit, has been renewed for the subsequent policy year. All aspects of pre-natal care, delivery and post-natal care (including the new born infant(s)' own routine tests and consultations) are covered, in aggregate, up to the limit shown for this benefit. Where a waiting period applies prior to any upgrade in cover this benefit, after the upgrade, will be restricted to the terms applicable to the original plan until the member has been covered under the upgraded plan for a period of not less than 12 consecutive months and has effected the annual renewal of the upgraded plan. Where the member effects a downgrade of their policy at the annual renewal benefit will be restricted to the level of cover provided by the lower grade plan in any event regardless of when the first pre-natal consultation was undertaken.
31. Vaccinations for children up to	AED/QAR 1,000, OMR/BHD 100 Age: 6 years	Cover is for children up to the age shown, born to parents covered under this plan where the child has been added to the parent's policy in accordance with our rules. Please ask us for further details. Benefit is only payable for recognized, necessary, infant/child vaccinations.

Other Benefits - continued		
32. Routine dental care up to	AED/QAR 3,000, OMR/HBD 300 9 month waiting period A coinsurance of 20% applies to this benefit.	This benefit provides for dental consultation, extraction, composite and amalgam fillings, root canal treatment, scaling, bridgework, crowns (at a grade appropriate to restore function only) and the treatment of gum disease. A co-insurance charge will apply as shown to all the above mentioned eligible treatments. This amount will be payable by the member. No deductible other than the co-insurance applies to this benefit.
33. Ancillary equipment	AED/QAR 500, OMR/BHD 50	Benefit is payable for crutches, wheelchairs, neck, back or leg braces and trusses required in support of eligible medical treatment. We reserve the right to determine whether the use of such equipment is appropriate.
34. Wellbeing	Included	Personal Support Line (PSL) is a 24/7 365 day telephone support service which provides free access to a range of specialist personal support on issues like, relationships, work pressures, stress management and family problems. You have access to trained and qualified English & Arabic speaking counseling experts who can provide professional support on any personal issues or challenges you or your family may be experiencing. Available to you and your immediate family members living in the same household. You can call AXA ICAS as often as you need to, whether it is about the same problem or other issues you find yourself having to face. The service is completely confidential and remains between you and your counselor. No information is disclosed without your consent. This unique service is available 24/7, 365 days a year and is accessed through the specific PSL country number. Please see enclosed PSL leaflet.
35. Personal accident	AED/QAR 75,000, OMR/BHD 7,500	We will pay the amount of Benefit shown in the Schedule if any of the Insured Party shall during the duration of the Policy sustain accidental bodily injuries which independently of any other cause results in death. Accident/Accidental: means a sudden, violent, external, unforeseen and identifiable event, whose action was not intended by the Insured Party, excluding all causes directly related to an illness suffered by the Insured Party that occurs after the effective date of the contract and produces direct pathological signs and symptoms.

Note: Policies are not automatically renewed at the policy anniversary unless otherwise agreed by contract. Policies are, in any event, issued on a 'Notice of Cancellation at Anniversary Date' basis.

Policies will therefore lapse at their anniversary unless renewal has been effected by the member/policyholder/group, accepted by us and the premium paid.

This benefits table must be read in conjunction with the terms of your membership agreement and any guidelines issued to you.

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