Benefits Schedule

MyHEALTH Qatar

Seib
تأمين وإعادة تأمين
INSURANCE & REINSURANCE

April International

MyHEALTH
BENEFITS SCHEDULE

The Benefits Schedule provides a summary of the cover provided per person per period of insurance, unless stated otherwise. It should be read in conjunction with the Terms and Conditions. Capitalised terms have the meanings given to them in the Definitions section of the Policy Terms and Conditions. All limits and monetary amounts shall in all instances be in US$. All claims must be medically necessary, reasonable, and customary.

OVERALL ANNUAL LIMIT	ESSENTIAL	EXTENSIVE	ELITE
The overall maximum amount we will pay per person per Period of Insurance.	$ 1,500,000 or $3,000,000	$3,000,000	$5,000,000
AREA OF COVER			
Area of Cover Options Cover applies within the selected area of cover.	Worldwide Worldwide Excluding USA		
Out of Area Cover Cover for Medically Necessary Inpatient and Outpatient treatment received outside the selected Area of Cover, limited to Sudden Illness or Injury occurring during a temporary trip.	Services rendered outside of the area of cover are covered up to $50,000 per Period of Insurance and for up to 30 days of treatment only if they are directly caused by a sudden illness or injury occurring during the first 30 travel days of any trip outside the area of cover.	Services rendered outside of the area of cover are covered up to $100,000 per period of insurance and for up to 45 days of treatment only if they are directly caused by a sudden illness or injury occurring during the first 30 travel days of any trip outside the area of cover.	
MEDICAL PROVIDER NETWORK			
The medical providers where you may receive treatment as per the benefits listed in your Inpatient, Outpatient and Maternity modules.	Select your network from the choices below: **Standard:** Full coverage is available at all medical providers, except for selected providers in Qatar. Treatment at these selected providers will be subject to a 30% co-insurance. **Premium:** Full coverage is available at all medical providers		

INPATIENT MODULE One Inpatient Plan must be selected and forms the basis of your cover. Pre-authorisation is required for the following services.			
Inpatient Plan Options	ESSENTIAL	EXTENSIVE	ELITE
ANNUAL DEDUCTIBLE OPTIONS			
Only applies to the Inpatient Plan	Nil $500 $1,500 $3,000 $5,000 $10,000		

INPATIENT MODULE - CONTINUED	ESSENTIAL	EXTENSIVE	ELITE
HOSPITAL AND DAY-PATIENT BENEFITS			
Hospital Room and Board Accommodation and meals provided during a covered hospitalisation.	Single Occupancy Room		
Hospital Services Includes: ► Intensive Care Unit (ICU) ► Theatre fees ► Blood, dressings, medicines, and drugs ► Diagnostic scans and tests ► Invasive endoscopic examinations ► Professional fees ► Surgical implants ► Prescribed Medical Aids and Devices ► Reconstructive surgery ► Emergency room (ER) treatment	Fully Covered		
Home Hospitalisation / Nursing at Home Hospital-level nursing care provided at home when prescribed by a physician.	Fully Covered		
Advanced Medical Imaging MRI, CT, and PET scans.	Fully Covered		
Parental Accommodation Accommodation for a parent accompanying a dependent child under the age of 18 during hospitalisation.	Fully covered		
External Prosthesis External prosthetic devices prescribed by a physician and required in connection with covered inpatient treatment or surgery.	$2,000	Fully covered	Fully covered
Mental and nervous conditions Inpatient treatment for eligible mental and nervous conditions.	$5,000	Fully covered	Fully covered
Road Ambulance Transportation services to or from hospital, when medically required and prescribed.	Fully Covered		
Hospital Cash Benefit A daily cash benefit where you are hospitalised at no cost to us.	$150 per night Up to a maximum of 30 nights	$200 per night Up to a maximum of 45 nights	$200 per night Up to a maximum of 45 nights
Return home cash benefit Where you elect to receive medically necessary inpatient or day-patient treatment outside your country of residence. The reasonable cost of an economy-class ticket for you only is reimbursed. All treatment must be pre-authorised by us and cost-effective compared to treatment in your country of residence.	$500	$1,000	$1,000
PRE- AND POST-HOSPITALISATION BENEFITS			
Pre Hospitalisation Treatment Physician consultations, diagnostic scans and tests, medicines, drugs, and dressings prescribed by a physician prior to admission for a covered hospitalisation.	Fully covered up to 30 days before a covered confinement	Fully covered up to 90 days before a covered confinement	Fully covered up to 90 days before a covered confinement
Post Hospitalisation Treatment Physician consultations, diagnostic scans and tests, medicines, drugs, dressings, and physiotherapy prescribed by a physician following discharge from a covered hospitalisation.	Fully covered up to 30 days after a covered confinement	Fully covered up to 120 days after a covered confinement	Fully covered up to 120 days after a covered confinement
Rehabilitation Treatment Treatment received as an inpatient or day-patient following a covered hospitalisation, provided as part of a structured rehabilitation programme, and including physiotherapy, occupational therapy, and speech therapy. Admission must take place within 2 weeks of discharge from a covered hospitalisation.	Fully covered up to 30 days	Fully covered up to 90 days	Fully covered up to 90 days

INPATIENT MODULE - CONTINUED	ESSENTIAL	EXTENSIVE	ELITE
SPECIFIED CONDITIONS AND TREATMENTS - DEDICATED (OVERRIDING) LIMITS The benefits listed under this section replaces standard inpatient and outpatient benefit limits. No other inpatient or outpatient benefits apply unless expressly stated. The following still apply: Maximum Annual Limit, Selected Network option, Inpatient Deductible (including where treatment is received on an outpatient basis under these benefits), Selected Room Category (where applicable), and any applicable Palliative Treatment limit.			
Cancer Treatment Consultations, diagnostic scans and tests, medicines and drugs, chemotherapy, radiotherapy, and targeted therapy related to active cancer treatment, received as an inpatient, day-patient, or outpatient. Includes: ► Cancer-related appliances (including wigs, head coverings, and mastectomy bras) ► Counselling provided by a registered psychologist or counsellor.	Fully Covered Cancer-related appliances and Counselling not covered	Fully covered Cancer-related appliances and Counselling capped at $1,000	Fully covered Cancer-related appliances and Counselling capped at $1,000
Kidney Dialysis Treatment received as an inpatient, day-patient, or outpatient.	Fully Covered	Fully Covered	Fully Covered
HIV/AIDS Treatment received as an inpatient, day-patient, or outpatient, including testing, monitoring, and antiretroviral therapy. A waiting period of 3 years applies (please refer to Waiting Periods Paragraph in the Policy Terms and Conditions).	$5,000	$20,000	$20,000
Hospice or Palliative Treatment Inpatient, day-patient, or outpatient care focused on pain relief, symptom control, and comfort for members with a life-limiting or terminal condition.	$50,000 lifetime benefit	Fully Covered	Fully Covered
Emergency Dental Treatment Inpatient dental treatment required to restore or repair damage to sound natural teeth as a direct result of an accident, provided that treatment is received within fourteen (14) days of the date of the accident. Excluding damage caused by normal wear and tear, biting or chewing.	Fully Covered	Fully Covered	Fully Covered
Preventive (Prophylactic) Surgery This benefit covers medically necessary preventive surgeries to remove tissues, organs, or glands that do not yet contain cancer cells but have a high probability of becoming cancerous in the future. The goal of these surgeries is to reduce the risk of future health issues. Coverage is limited to surgeries recommended by a qualified medical professional and subject to case-by-case review by our Medical Team or a qualified physician approved by us.	No cover	$50,000	$50,000
SPECIFIED CONDITIONS AND TREATMENTS - SUB-LIMITS The benefits listed under this section operate as sub-limits within the applicable inpatient or outpatient modules. If the Outpatient module is not selected, outpatient treatment is not covered.			
Chronic Conditions	Covered		
Congenital and Hereditary conditions	No Cover	$200,000 lifetime benefit	$200,000 lifetime benefit
Neonatal disabilities Applicable only where the newborn has been formally added to the Policy as an insured person and in accordance with the Terms and Conditions.	No Cover	$200,000 lifetime benefit	$200,000 lifetime benefit
Complication of pregnancy Treatment of complications arising during the antenatal stage of pregnancy.	Covered		
Organ and Bone Marrow Transplant Treatment for transplantation of cornea, kidney, heart, liver, lung, or bone marrow. Includes: ► donor-related surgical expenses for the removal of an organ. ► Stem Cell Treatment and harvesting immediately prior to treatment.	Covered no cover for donor organ removal no cover for stem cell treatment	Covered $20,000 for donor organ removal $200,000 lifetime benefit for stem cell treatment	Covered $20,000 for donor organ removal $200,000 lifetime benefit for stem cell treatment
EMBEDDED MEDICAL SERVICES			
Teleconsultation	Included		
Second Medical Opinion	Included		
24/7 Emergency Medical Assistance (EMA)	Included		

OUTPATIENT MODULE Outpatient Plans are optional and may be combined with any selected Inpatient Plan.			
Outpatient Plan Options	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
ANNUAL OUTPATIENT LIMIT			
The annual cumulative limit for all benefits shown in the Outpatient Module.	$10,000	Up to overall annual limit	Up to overall annual limit
CO-INSURANCE OPTION			
Co-insurance applies to all services under the Outpatient Module.	Choice of nil or 20%		
ROUTINE OUTPATIENT BENEFITS			
Physician consultation fees Consultations with General Practitioners and Specialists.	Fully Covered		
Medicines, Drugs and Dressings when prescribed by a physician.	Fully Covered		
Diagnostic Scans and Tests Laboratory tests, pathology, ultrasound, ECG, X-ray, and other minor diagnostic procedures prescribed by a physician.	Fully Covered		
Advanced Diagnostic Imaging CT scan, PET Scan, and MRI, when prescribed by a physician.	Fully Covered		
Outpatient Surgery Minor surgical procedures performed without hospital admission and not classified as inpatient or day-patient treatment.	Fully Covered		
Medical appliances and Mobility aids Purchase or rental of medical appliances and mobility aids when prescribed by a physician.	$1,500	$5,000	Fully covered
Mental and nervous conditions Consultations with physicians, psychologists and psychotherapists, diagnostic tests and prescribed medicines for eligible mental and nervous conditions, or developmental disorders.	$2,500	$5,000	$10,000
Hormone replacement therapy Medicines and drugs prescribed by a physician for medically necessary hormone replacement therapy for clinical conditions such as premature ovarian insufficiency. This benefit does not extend to hormone replacement therapy related to natural ageing, menopause, or gender transition.	No cover	Fully Covered	Fully Covered
COMPLEMENTARY AND ALTERNATIVE THERAPIES			
Physiotherapy Physiotherapy sessions prescribed by a physician. Maximum of ten (10) sessions per prescription. A new medical prescription and medical report are required for continued treatment thereafter.	$1,500	$5,000	Fully covered
Annual cumulative limit for all benefits shown below.	$1,000	$2,000	Up to overall annual limit
Complementary Therapies Consultations and prescribed medicines provided by recognised complementary therapy practitioners, limited to chiropractors, osteopaths, podiatrists, speech therapists, occupational therapists, and orthoptists. When medically necessary following an illness or injury.	Fully covered		
Alternative medicine Consultations and prescribed medicines provided by recognised alternative medicine practitioners, limited to acupuncturists, Traditional Chinese Medicine practitioners, homeopaths, naturopaths, dietician, nutritionist, ayurvedic practitioners and hypnotherapists. When medically necessary following an illness or injury.	up to one visit per day and up to $100 per visit	up to one visit per day and up to $100 per visit	Fully covered

OUTPATIENT MODULE - CONTINUED	ESSENTIAL	EXTENSIVE	ELITE
PREVENTIVE CARE			
Routine Health Screening ► Mammography for women aged 40 years and above ► Pap smear for women aged 19 and above ► Prostate screening for men aged 40 years and above ► Child health screening evaluating medical history, physical and development assessment, school entry health check, hearing check and or diabetic screening. 0–3 years: up to 2 per year; 4–15 years: 1 per year	$400	Fully covered	Fully covered
Medical Check-Up General health check or standalone tests and scans performed in the absence of a diagnosis.	$500	$1,000	$2,500
Vaccinations Mandatory and travel-related vaccinations and associated physician consultation fees.	$150	$250	Fully covered
Over the counter (OTC) drugs Non-prescription pharmacy items limited to: • vitamins and mineral supplements; • smoking cessation products; • medically indicated topical treatments.	No cover	$100	$200

MATERNITY MODULE Maternity Plans are optional and available to female insured persons aged 19 to 45 who have selected an Extensive or Elite Inpatient Plan with a nil deductible, together with an optional Outpatient Plan.			
Maternity Plan Options	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
MATERNITY AND FERTILITY BENEFITS A waiting period of 366 days applies (please refer to Waiting Periods Paragraph in the Policy Terms and Conditions).			
Pregnancy and Childbirth ► Prenatal and post-natal services, including physician consultations, diagnostic scans and tests, medicines and drugs, licensed midwifery and certified doula services, vitamins and supplements, complementary medicine, complementary maternity therapies, prenatal classes (held by a physician or a midwife); ► Natural delivery, elective c-section, or home birth; ► Up to seven (7) days of nursery care; ► Complications of pregnancy following assisted conception; ► Medical necessary abortion.	$7,000 per pregnancy	$10,000 per pregnancy	$15,000 per pregnancy
Complications of Childbirth ► Emergency caesarean section ► Medically necessary caesarean section	Additional $8,000	Additional $10,000	Additional $15,000
Fertility treatment Diagnostic testing and medically approved fertility treatments for individuals with a confirmed diagnosis of infertility, including fertility medication, ovulation induction, and assisted reproductive procedures such as IVF. Subject to pre-authorisation.	No cover	No cover	$20,000 lifetime limit with 40% co-insurance

DENTAL AND OPTICAL MODULE Dental Plans are optional and may be combined with any selected Inpatient Plan.			
Dental Plan Options	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
DENTAL BENEFITS			
Annual cumulative limit The annual cumulative limit for all dental benefits.	$1,500	$2,500	$4,500
Preventive and Routine Dental Treatment Routine dental examinations, cleanings, X-rays, fillings, and simple extractions, including: ► dental check-ups or examinations (limited to one per insurance year); ► routine tooth cleaning, scaling, and prophylaxis (limited to one per insurance year); ► X-rays; ► crowns; ► inlays, onlays, or fillings; ► simple extractions, mouth guards, and sealants.	Fully covered up to overall dental limit		
Major Dental Treatment Advanced dental procedures including bridges, implants, periodontal and endodontic treatments, including but not limited to: ► dentures, bridges, inlays, and dental implants; ► surgical removal of impacted or unerupted teeth or roots; ► treatment of temporomandibular joint (TMJ) disorders; ► periodontal and endodontic treatments such as root canal therapy or apicoectomy; ► treatment of illnesses of the oral mucosa and related diagnostic services; ► prescribed medicines for pain management related to covered dental treatment. A waiting period of 180 days applies (please refer to Waiting Periods Paragraph in the Policy Terms and Conditions).	Fully covered up to overall dental limit with 50% co-insurance		
Orthodontic treatment Orthodontic treatment commenced before the age of 16. A waiting period of 180 days applies (please refer to Waiting Periods Paragraph in the Policy Terms and Conditions).	No cover	Fully covered up to overall dental limit with 50% co-insurance	Fully covered up to overall dental limit with 50% co-insurance
OPTICAL BENEFITS			
Optical ► Eyesight examination (limited to one per insurance year); ► Visual aids intended to correct vision, limited to lenses, spectacles, frames, and contact lenses, and only when prescribed by an ophthalmologist or optician.	$250 with 20% co-insurance	$250 with 20% co-insurance	$500 with 20% co-insurance
Laser Treatment for Vision Correction Laser treatment for vision correction, including myopia, hyperopia, and astigmatism. A waiting period of 366 days applies (please refer to Waiting Periods Paragraph in the Policy Terms and Conditions).	No cover	No cover	$1,500 with 20% co-insurance

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