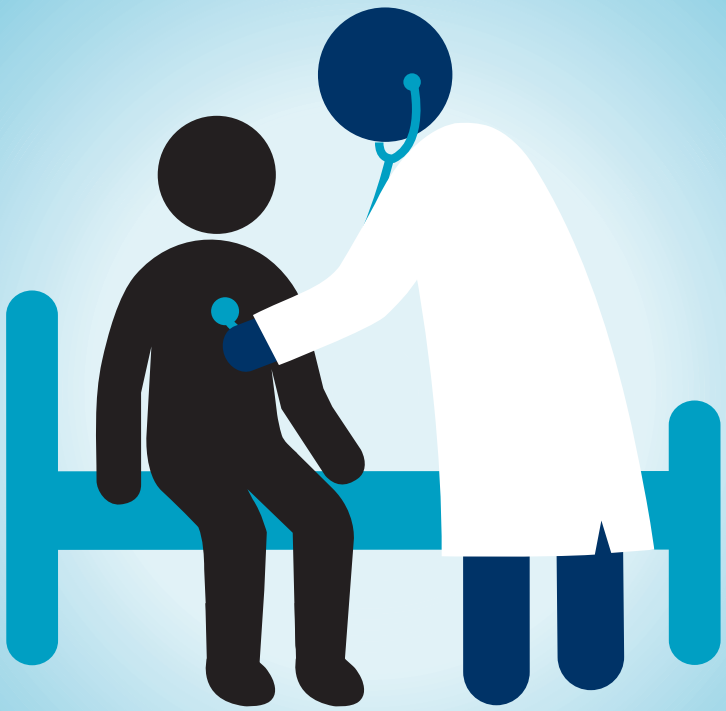
Participant's Guide to **t'azur** Group Medical Plan

t'azur

together in trust



Introduction

t'azur Company b.s.c. (c), in partnership with your employer is providing you with a comprehensive healthcare plan, and we welcome you as a member of your company's Group Medical Takaful scheme.

This booklet has been designed to provide you with a clear and concise summary of the main terms, conditions and benefits of your company's Group Medical Takaful scheme, as well as information relating to claims and where you can receive medical treatment. This booklet is split into the following sections:

- Eligibility — who is qualified for coverage under your company's Group Medical Takaful scheme
- Important Definitions — terms and conditions that are important for you to understand
- What we pay for — an overview of what medical treatment is covered by **t'azur**
- What we do not pay for — a summary of the treatments not covered by **t'azur**
- How to make a claim — a step by step process for making a claim for medical treatment
- The Membership Card — what it is and how to use it
- Emergency Treatment Abroad — what to do in case you require medical treatment abroad
- Contact Numbers — a one-pager with key contact details

Eligibility

To be eligible for receiving healthcare cover under your company's Group Medical Takaful scheme, you either have to be an employee of the company or a dependant of an employee. These terms are defined below:

Employee

- All full-time permanent employees actively at work or on normal annual leave at the time of joining the company. If the employee is absent from work through reasons of injury or illness, cover will commence after he / she has been actively at work for two consecutive weeks.

Dependants

The following Dependants of the Employee are eligible for coverage under this Plan, provided they are residing in the Kingdom of Bahrain:

- Legal spouse(s) of the Employee
- Unmarried children, step children and legally sponsored children of the Employee, provided they are 18 years or younger. If the dependant is over 18 years, he / she will only be eligible if enrolled as a full-full time students at a school, college or university and is not over 24 years of age.

Important Definitions

What is Co-Payment?

Co-payment is the amount you are required to pay for the cost of services after you have met your deductible. The co-payment is expressed as a percentage of the treatment costs.

What is Deductible?

A Deductible is the amount you are responsible to cover towards the cost of each out-patient consultation.

What is Out-Patient Treatment?

Out-Patient Treatment is all medically necessary treatments and services that do not require hospitalisation during the day or overnight nor necessitate specialised medical attention.

What is In-Patient Treatment?

In-Patient Treatment is where the covered member requires hospitalisation for a minimum of one night for specialised medical attention and care, before, during and / or after the treatment and which cannot be performed on an out-patient basis.

What is my Membership Card and how do I use it?

Your individual personalised membership card is issued by **t'azur** for you (and your dependants if applicable) to identify you as a covered member under your company's Group Medical Takaful scheme. You should present this card when receiving treatment at our Designated Network Providers to gain access to the medical treatments covered under your company's scheme.

What are Designated Network Providers?

Designated Network Providers are the hospitals, clinics, laboratories, diagnostic centres, pharmacies and other medical facilities that are part of our network of Preferred Medical Providers. **t'azur** has a Direct Billing arrangement with these providers to make the claims process easier. A list of these providers is available with your company's Human Resources department, or at www.tazur.com.

What is Direct Billing?

Direct Billing means that any costs resulting from Medical treatment any Designated network provides is directly settled by **t'azur** and paid directly to the provider. You don't have to pay anything (except Deductible and Co-payment and any other costs not covered where applicable).

What is Pre-Authorisation and when is it required?

Pre-authorisation is the review and approval of treatments by **t'azur** prior to (or concurrent) with the treatment date. This is to ensure that they are undertaken within the scope of cover of the Plan terms and conditions, benefits and exclusions. Pre-authorisation is required for all in-patient and day-care treatment. More information as to which treatments require pre-authorisation can be found in the Policy document and schedule of benefits between **t'azur** and your employer.

What is the Policy Document and Schedule of Benefits?

The Policy document and schedule of benefits is a contract between **t'azur** and your employer fully detailing all of the medical benefits available to you. The schedule of benefits will list in detail the benefits and associated limits available to you. This booklet is a guideline to your medical benefits and the Policy document and schedule inform about the details.

What are Reasonable and Customary Charges?

The amount **t'azur** recognises for payment for a particular medical procedure. It is based on what is considered "reasonable" for that procedure in accordance with the market price in the country where the treatment was provided or in the country of residence, whichever is less.

What we pay for

Your company's Group Medical scheme will cover certain benefits, and also exclude certain benefits. You are advised to refer to your schedule of benefits for a detailed summary of what is covered under your scheme before seeking medical treatment. This section will list some of the typical in-patient and out-patient benefits, and also some other medical benefits that you may be eligible to receive.

In-Patient Benefits

These includes the following:

- Hospital services such as operating theatre, anaesthesia, laboratory, radiology, and various therapies including physiotherapy, chemotherapy, radiotherapy
- Day-Care treatment
- Ambulance services to the nearest adequate hospital
- Surgeon and anaesthesiologist fees, and physician and specialist consultations as related to the original cause of hospitalisation only
- Intensive care unit and coronary artery disease unit
- Private nursing care when pre-approved
- Companion room and board charges if patient is below age twelve

Out-Patient Benefits

These includes the following:

- Physician's Consultation
- Diagnostic tests & procedures, blood tests and other laboratory tests
- ECG and ECG monitoring, X-Rays, CT Scan, Nuclear Scan, Magnetic Resonance Imaging (MRI)
- Pharmaceuticals
- Physiotherapy, Osteopathy and Chiropractic treatment

Other Benefits

If selected for cover by your company, you may be eligible to receive

- Dental benefits; extraction, filling, root canal treatment & gum treatment, medicines
- Optical benefits; cost of lenses excluding frames, and contact lenses
- Maternity benefits; ante-natal, post-natal, delivery and legal abortion/miscarriage
- Pre-existing and chronic conditions
- Alternative medicine
- Traditional Chinese medicine
- Health Check-ups
- Hormone Replacement Therapy
- Home Nursing
- Major Organ Transplant

What we do not pay for

As with every Group Medical scheme, certain medical treatments are excluded from coverage. Again, you are advised to refer to your schedule of benefits for a detailed summary of what is not covered under your scheme before seeking medical treatment.

Listed below are some typical excluded treatments and / or cause:

- Birth defects
- Self-inflicted injuries
- Participation in illegal actions
- Hazardous sports
- Check-ups, vaccinations and any preventive treatment
- Consumption of alcohol & illegal drugs
- Work-related injuries / illnesses
- AIDS / HIV
- Sexual dysfunction
- Cosmetic treatment
- Tests or treatment related to infertility
- War, invasion, act of foreign enemy

Please refer to the policy wording for any further details.

How to make a Claim

Where do I go to get medical treatment?

If you need to see a doctor or go to a hospital, please consult the directory of Designated Medical Providers. If you are treated in one of these facilities, you will not have to pay any charges, other than any deductible applicable, co-payment and any charges not covered by your scheme. The cost of the treatment will be paid directly to the hospital on your behalf by **t'azur**. You are free to go to any other licensed medical practitioner outside the network of Designated Medical providers, but you will have to pay for your treatment and then submit a claim to **t'azur** Company. Please refer to your HR department or www.tazur.com for a list of Designated Medical Providers.

How do I get medical treatment at a Designated Medical Provider?

When you visit a doctor or go to the hospital, please make sure:

- You have your current membership card with you at all times
- You show your membership card to the receptionist when you arrive
- Complete, sign and date the 'Patient Section' of the Primary Claim Form provided by the receptionist
- You pay to the medical facility, upon receiving treatment, all medical expenses (deductibles, co-payment) and any other services that are not covered by your scheme
- You know your medical benefits
- You contact your doctor before your appointment if pre-authorisation is required for treatment

What happens if I need further treatment at a Designated Medical Provider?

If the doctor thinks that you need an operation or further specialist treatment, you will be given another appointment. **t'azur's** Third Party Administrator will advise your specialist / hospital in writing of the treatment cost to be covered.

The following services and / or conditions cannot be received at a medical facility without prior approval obtained from **t'azur**:

- In patient treatment
- Daycare treatment, surgical procedure
- MRI, CT Scan, Nuclear Scan
- Bone Densitometry, Hormone Assay
- Investigations costing over BD 100
- Dental & gum treatment
- Physiotherapy, osteopathy
- Maternity treatments (In-patient only)
- Long-term medication (more than one month)

How do I get medical treatment at hospitals or medical facilities not in the list of Designated Medical Providers?

You will have to pay for your treatment and then claim for a refund of the expenses incurred by sending the original receipted invoices together with a completed claim form to **t'azur** for refund. A claim reimbursement form can be obtained or down loaded from www.tazur.com.

Important Notes:

- Remember to take a claim form with you when you visit the doctor or hospital. The cost of treatment will not be refunded unless we receive a properly completed claim form and receipted invoice.
- Please be aware that if you access a provider outside the network you may not be reimbursed the full amount. Please refer to your schedule of benefits for details.

Your responsibilities

- Complete, sign and date the 'Patient Section' of a Primary Claim Form and submit to your attending doctor
- Ensure the following is detailed and completed by your attending doctor:
  - Details of diagnosis
  - Details and date of treatment
  - Name and signature of attending doctor
  - Name and stamp of hospital / clinic
- Pay for the treatment costs with the hospital / clinic directly and obtain an itemised invoice and receipt for your payment
- Return the completed 'Primary Claim Form' and all supporting documentation to **t'azur** in order to receive the applicable claim amount

t'azur may reject any claim for the following reasons:

- Lack of full diagnosis on the doctor's report
- Appropriate invoices / receipts not provided
- Medical expenses claim form not completed properly
- Insufficient medical information concerning the treatment
- Treatment not covered under the scheme, stated in the 'General Exclusions'
- Employee or his dependent is not covered
- Lack of information on the claim form to identify patient such as ID number, full name and scheme name

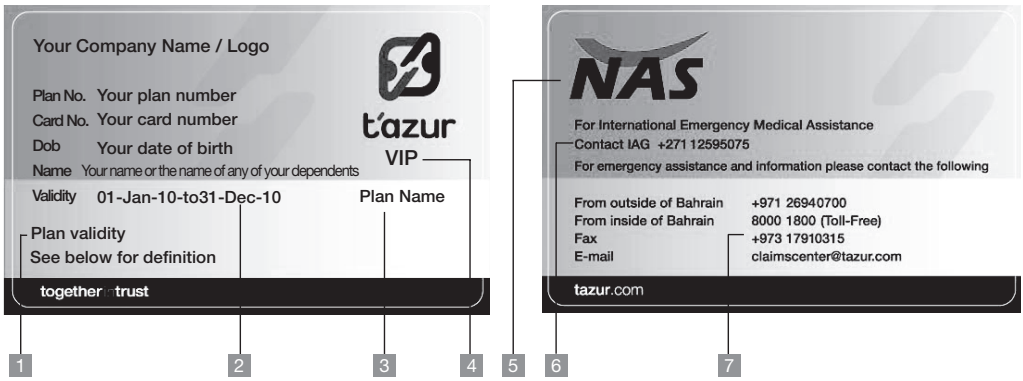
How you obtain the benefits your plan provides?

In any event, if you are receiving treatment in any part of our global network you must always identify yourself as a member to ensure that your treatment enjoys the advantages of our negotiated rates. Failure to do this may expose you to additional costs which you will have to bear.

The Membership Card

Your individual personalised membership card is issued by **t'azur** for you (and your dependants if applicable) to identify you as a covered member under your company's Group Medical Takaful scheme. You should present this card when receiving treatment at our Designated Network Providers to gain access to the medical treatments covered under your company's scheme.

Below are a few key pieces of information you should be aware of:



1 On the front of your Membership Card is information that tells the Medical Providers what benefits you are eligible for, any deductibles or co-payments to be applied, and other important information. The following abbreviations are used:

CN, GN, RN	This designates to which network you have access to. Please refer to the network directory which can be obtained from your HR / finance department or www.tazur.com
IN	In-Patient Treatment
OUT	Out-Patient Treatment
D	Deductible
CO	Co-Payment
DB	Dental Benefit
MB	Maternity Benefit

In cases where Pre-Existing and Chronic Conditions are not covered, this will be explicitly mentioned on the Membership Card.

2 These dates are the dates that you are covered under your company's Group Medical Scheme

3 If you have one of **t'azur's** structured plans, the plan name will appear here

4 If your member card states VIP here, you will receive preferential treatment at Designated Network Providers

5 **t'azur's** Third Party Administrator

6 Contact information for emergency medical assistance abroad

7 Contact details for information on medical benefits

Emergency Treatment Abroad

Emergency Treatment Abroad can be received by contacting International Assistance Group (IAG) on +271 1259 5075. This number can also be found on the reverse of your membership card. IAG's Operations Centre is staffed 24 hours a day, 365 days a year with trained multilingual and medical personnel, including doctors and nurses, to advise and assist you quickly and professionally in a medical emergency.

By calling IAG, you will be immediately put in contact with:

- A global network of pre-qualified medical providers
- A state-of-the-art Operations Centre with worldwide response capabilities
- Experienced crisis management professionals
- Air and ground ambulance service providers

International Assistance Group's (AIG) completely arranges and pays for all of the assistance services it provides without limits on the covered cost. This alleviates many of the obstacles and potential expenses that can be caused by medical emergencies away from home. It is important to keep your identification card with you at all times so that you can call for services whenever you need them.

Contact Numbers

If you require any assistance or need any clarification, please contact the following numbers

- From outside of Bahrain: +971 2694 0700
- From inside of Bahrain: 8000 1800 (Toll free)
- Fax: +973 1791 0315
- E-mail: claimscenter@tazur.com
- International Emergency Medical Assistance: +271 1259 5075 (this number is manned 24 hours a day, 365 days a year)

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