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| **ANNEX A BENEFIT & PRICE SCHEDULE** | | | | |
| **COMPANY NAME:** | | | | |
| **INSURED COUNTRY: Lebanon** | | | | |
| **GROUP MEDICAL** | | | | |
| **Benefit** | **Recommended Benefits** | | | |
| **Option 1 - Standard Coverage** | | **Option 2 - Premium Coverage** | |
| **Benefit Description and limits** | **Premium Amount (currency)** | **Benefit Description and limits** | **Premium Amount (currency)** |
| **Outpatient Benefit to cover** |  |  |  |  |
| Consultations (GP and Specialist) |
| Procedures (Pathology, Radiology and other diagnostic tests) |
| Chronic Medicines |
| Outpatient Maternity |
| Dentistry |
| Auxiliary Services |
| Optical |
| Well being benefit |
| Laboratory, X-Ray, Pharmacy, Diagnostic Services, Physiotherapy, and Prescribed Medical aid. |
| Diagnostics consultation. |
| Specialist consultation. |
| Physiotherapy treatment |
| Psychiatric treatment |
| Registered Chronic Conditions |
|  |
|  |
| **Inpatient Benefit to cover** |  |  |  |  |
| In hospital accommodation, specialist(s), operating room (OR) costs and ancillary OR services (please list costs of semi-private and private rooms) |
| Emergency Ambulance |
| Inpatient Maternity (childbirth) |
| Inpatient Maternity complications (post -delivery) |
| Neonatal care |
| High care and intensive care |
| Psychiatric hospitalization |
| Prosthesis |
| External medical appliances |
| Specialized Radiology(in and outpatient) |
| Hospitalization related to chronic conditions |
| Prescribed Optical Surgery |
| Prescribed Dental Surgery |
| Major Disease Benefit (Cancer treatment, Kidney dialysis etc.) |
| In hospital surgery, including ICU, Day Surgery. |
| Laboratory investigative, X rays, ultrasound, ECG, MRI Scans |
| Prescribed drugs, dressings, surgical appliances, and nursing procedures |
| Doctors, surgeon & Specialist fee |
|  |
| **Emergency Treatment outside Area of Coverage, including internationally** |  |  |  |  |
| Description and threshold for emergency treatment while travelling outside area of coverage |
| **Emergency Response** |  |  |  |  |
| ·       Emergency Ambulance Services. |
| ·       Emergency Treatment outside area of cover. |
| **Adult Health check-ups** |  |  |  |  |
| ·       Physical examination |
| ·       Diagnostic Testing (please list) |
| ·       Vaccines |
|  |
|  |
| **Pediatric Health Check-ups** |  |  |  |  |
| ·       Physical examination |
| ·       Diagnostic Testing (please list) |
| ·       Vaccines |
|  |
| **Other auxiliary benefits** |  |  |  |  |
| For example, Physiotherapy Treatment, etc. |
| **Lodger fees (if applicable)** |  |  |  |  |
| Private Room accommodation for accompanying parent for child below 12 years |
| **TOTAL APPLICABLE PREMIUM** |  |  |  |  |
| **GROUP LIFE** | | | | |
| **Benefit** | **Recommended Benefits** | | | |
|  | **Option 1 - Standard Coverage** | | **Option 2 - Premium Coverage** | |
| **The provider should specify riders(s) where they apply** | **Benefit Description and limits** | **Premium Amount (currency)** | **Benefit Description and limits** | **Premium Amount (currency)** |
| **Group Life** |  |  |  |  |
| Death, any cause |
| Accidental Death |
| Permanent Partial Disability |
| Permanent Total Disability |
| Personal Accident Premiums (please specify age brackets and thresholds) |
|  |
| **TOTAL APPLICABLE PREMIUM** |  |  |  |  |
| **Please indicate whether coverage is national or global** | | | | |
| **WORKMANS COMPENSATION** | | | | |
| **Benefit** | **Recommended Benefits** | | | |
| **The provider should specify riders(s) where they apply** | **Option 1 - Standard Coverage** | | **Option 2 - Premium Coverage** | |
| **Benefit Description and limits** | **Premium Amount (currency)** | **Benefit Description and limits** | **Premium Amount (currency)** |
| **Life** |  |  |  |  |
| Death, any cause |
| Permanent Partial Disability |
| Permanent Total Disability |
| Personal Accident Premiums (please specify age brackets and thresholds) |
| **TOTAL APPLICABLE PREMIUM** |  |  |  |  |
| **Please indicate whether coverage is national or global** | | | | |