

# What you're covered for

The following **table of benefits** sets out the cover provided by each **plan**. The **plan you** have is as shown on **your Certificate of Insurance**. We will pay only for the **treatment** or services stated in the **table of benefits** relating to **your plan**.

Each benefit limit in the **table of benefits** is expressed in US dollars, sterling, and Euros. The currency of the benefit limits that **we** will apply to **your plan** is shown on **your Certificate of Insurance**.

The limits shown in the **table of benefits** are the maximum amounts **we** will pay after the application of any **excess** and **co-insurance**, and will be subject to the annual benefit limit and any other specified applicable benefit limits.

Certain benefits in the **table of benefits** specify a **waiting period**. **You** must be covered by the same **plan** for the full duration of the specified **waiting period** before **you** can **claim** for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**.

Wherever the term *Full cover* appears in the **table of benefits**, this means a full refund of **reasonable and customary** charges, less any **excess** or **co-insurance** applicable to **your plan**, and subject to any limits that are specified anywhere else in the **table of benefits** for the type of **treatment** or care **you** receive.

Where there is a lifetime benefit limit, this is the maximum amount **we** will pay in respect of that particular benefit during **your** lifetime.

Certain benefits in the **table of benefits** are optional. **You** are only eligible for these benefits if **you** have selected them and they are stated on **your Certificate of Insurance**.

There are certain benefits in the **table of benefits** for which **you** must obtain pre-authorization. If **you** do not obtain pre-authorization for these benefits, **we** will only pay 80% of the **reasonable and customary** cost of **treatment**.

The **table of benefits** should be read in conjunction with the *What you're not covered for* section of this **agreement**.

**Key** ● Full cover within annual benefit limit ● Partial or limited cover ● No cover ● Optional cover

	Bronze	SilverLite	Silver	Gold
<b>Annual benefit limit</b> The overall maximum limit that each <b>insured person</b> can <b>claim</b> during any one <b>period of cover</b> .	US\$1,500,000 or £1,000,000 or €1,125,000	US\$1,500,000 or £1,000,000 or €1,125,000	US\$2,500,000 or £1,666,000 or €1,875,000	US\$5,000,000 or £3,333,000 or €3,750,000

**Hospital costs**  
Important notes:  

- You** must obtain pre-authorization for all benefits in this section.

	Bronze	SilverLite	Silver	Gold
<b>Hospital accommodation</b> Private hospital room - the cost of a standard single room with an en-suite bath or shower room, when <b>you</b> are an <b>in-patient</b> or <b>day-patient</b> . Semi-private hospital room - the cost of a standard shared room with an en-suite bath or shower room, when <b>you</b> are an <b>in-patient</b> or <b>day-patient</b> . Accommodation in a private hospital room is only available under the Bronze and SilverLite plans if <b>you</b> have selected this option.	<ul style="list-style-type: none"> <li><span style="color: green;">●</span> Semi-private hospital room</li> <li><span style="color: blue;">●</span> Private hospital room</li> </ul>	<ul style="list-style-type: none"> <li><span style="color: green;">●</span> Semi-private hospital room</li> <li><span style="color: blue;">●</span> Private hospital room</li> </ul>	<ul style="list-style-type: none"> <li><span style="color: green;">●</span> Private hospital room</li> </ul>	<ul style="list-style-type: none"> <li><span style="color: green;">●</span> Private hospital room</li> </ul>

	Bronze	SilverLite	Silver	Gold
<b>Hospital treatment</b> <b>Treatment you</b> receive while <b>you</b> are an <b>in-patient</b> or <b>day-patient</b> , including surgeons' and anaesthetists' and <b>doctors'</b> fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, <b>diagnostic tests</b> and physiotherapy. <b>We</b> will also pay for <b>pre-admission tests</b> that <b>you</b> undergo on an <b>out-patient</b> basis for <b>hospital treatment you</b> are scheduled to receive that is covered by <b>your plan</b> . <b>We</b> will also pay for <b>in-patient</b> surgical removal of impacted, buried or unerupted wisdom teeth. This is subject to a 12-month <b>waiting period</b> and covered only when the surgery is performed by a <b>medical doctor</b> (not a dentist) in a <b>hospital</b> (not a dental surgery) and under general anaesthetic.	<span style="color: green;">●</span> Full cover	<span style="color: green;">●</span> Full cover	<span style="color: green;">●</span> Full cover	<span style="color: green;">●</span> Full cover

Key ● Full cover within annual benefit limit ● Partial or limited cover ● No cover ● Optional cover

Bronze	SilverLite	Silver	Gold
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### Hospital costs (continued)

Important notes:

- You must obtain pre-authorisation for all benefits in this section.

#### Parent accommodation

The cost of one parent staying in **hospital** with a child under 18 years of age while the child is receiving eligible **treatment** covered by their **plan**.

● Full cover	● Full cover	● Full cover	● Full cover
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#### Local ambulance

The cost of a local road or air ambulance if **you** need **medically necessary hospital treatment** covered by **your plan**. Transport must be to the nearest available and appropriate **hospital** and an air ambulance is only covered if there is no viable alternative.

● Full cover	● Up to US\$1,600 or £1,065 or €1,200 per period of cover	● Full cover	● Full cover
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#### Hospital cash benefit

Payable for each night spent in a **hospital** when **you** receive **treatment** eligible for cover by **your plan** for which no charge is made by the **hospital**. Benefit is paid for up to a maximum of 60 nights per **period of cover**.

If selected, **your excess** will not be applied to this benefit.

● US\$150 or £100 or €113 per night	● US\$200 or £132 or €150 per night	● US\$200 or £132 or €150 per night	● US\$350 or £231 or €263 per night
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### Cancer treatment

Important notes:

- You must obtain pre-authorisation for all benefits in this section.

#### Cancer treatment

Cancer **treatment**, including chemotherapy, radiotherapy, immunotherapy, consultations, tests, scans, and drugs. **We** will also pay for restorative **dental treatment** following chemotherapy or radiotherapy.

● Full cover	● Full cover	● Full cover	● Full cover
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#### Cancer genome tests

The cost of tests to sequence the genes of cancer cells.

● Up to US\$6,000 or £4,000 or €4,500 per period of cover	● Up to US\$6,000 or £4,000 or €4,500 per period of cover	● Up to US\$6,000 or £4,000 or €4,500 per period of cover	● Up to US\$6,000 or £4,000 or €4,500 per period of cover
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#### Cash benefit upon diagnosis of cancer (6-month waiting period)

Payable if **you** are diagnosed with cancer. By *cancer* we mean the presence of tumours that consist of cells that are malignant, due to characteristics which can be shown microscopically. These cells can multiply and spread to other parts of the body uncontrollably (e.g. cancers such as breast cancer, lung cancer, bowel cancer, and cancers of the blood (also known as leukaemia)).

The following are not covered:

- non-melanoma skin cancer unless it has spread to lymph nodes or organs
- prostate cancer unless it has spread to other glands or organs

This benefit will not be paid if **you** were first diagnosed with any cancer before **you** were covered under the Gold **plan** for a period of six consecutive months.

● No cover	● No cover	● No cover	● US\$5,000 or £3,330 or €3,750 with a lifetime limit of one claim per insured person
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Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

## Cancer treatment (continued)

Important notes:

- You must obtain pre-authorisation for all benefits in this section.

### Wigs

Help towards the cost of a wig following chemotherapy, covered by **your plan**.

Partial or limited cover  
Lifetime limit of US\$150 or £100 or €113

Partial or limited cover  
Lifetime limit of US\$150 or £100 or €113

Partial or limited cover  
Lifetime limit of US\$150 or £100 or €113

Partial or limited cover  
Lifetime limit of US\$250 or £165 or €188

### Counselling

Consultations with a registered psychologist/counsellor when **you** have received cancer **treatment** covered by **your plan**, up to a lifetime limit of 10 consultations.

Drugs prescribed by a **medical doctor** for out-patient mental health treatment are covered under this benefit.

Partial or limited cover  
Lifetime limit of US\$500 or £330 or €375

Partial or limited cover  
Lifetime limit of US\$500 or £330 or €375

Partial or limited cover  
Lifetime limit of US\$500 or £330 or €375

Partial or limited cover  
Lifetime limit of US\$750 or £500 or €563

### Dietitian

Consultation with a registered dietitian when **you** have received cancer **treatment** covered by **your plan**, up to a lifetime limit of 2 consultations.

Partial or limited cover  
Lifetime limit of US\$100 or £67 or €75

Partial or limited cover  
Lifetime limit of US\$100 or £67 or €75

Partial or limited cover  
Lifetime limit of US\$100 or £67 or €75

Partial or limited cover  
Lifetime limit of US\$250 or £165 or €188

## Organ, bone marrow or tissue transplants

Important notes:

- You must obtain pre-authorisation for all benefits in this section.
- We only cover transplants carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO (World Health Organisation) guidelines.
- We do not cover any costs associated with the acquisition of the organ.

### Transplant and related treatment

Costs incurred while hospitalised, including anti-rejection drugs, and all related **out-patient treatment** required prior to and after the transplant.

Full cover

Full cover

Full cover

Full cover

### Donor costs

Medical costs associated with the donor as an **in-patient** or **day-patient**.

Partial or limited cover  
Up to US\$25,000 or £16,600 or €18,750 per transplant

Partial or limited cover  
Up to US\$25,000 or £16,600 or €18,750 per transplant

Partial or limited cover  
Up to US\$25,000 or £16,600 or €18,750 per transplant

Partial or limited cover  
Up to US\$25,000 or £16,600 or €18,750 per transplant

## Kidney dialysis

Important notes:

- You must obtain pre-authorisation for all benefits in this section.

Treatment for kidney dialysis while **you** are an **in-patient**, **day-patient** or **out-patient**.

Full cover

Full cover

Full cover

Full cover

Key ● Full cover within annual benefit limit ● Partial or limited cover ● No cover ● Optional cover

Bronze	SilverLite	Silver	Gold
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### Reconstructive surgery

Important notes:

- You must obtain pre-authorization for all benefits in this section.

A maximum of two surgeries per lifetime to restore **your** appearance after an **accident** or after surgery for cancer, provided the original **treatment** for the **accident** or cancer was paid for by **us**, and provided the reconstructive surgery takes place within two years of the **accident** or the original cancer surgery.

<p>● <b>In-patient, day-patient and post-hospital treatment</b> received within the 90-day period following the date <b>you</b> are discharged from <b>hospital</b></p>	<p>● Full cover</p>	<p>● Full cover</p>	<p>● Full cover</p>
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### Congenital conditions or hereditary conditions

Important notes:

- You must obtain pre-authorization for all benefits in this section.

**Treatment** for a **congenital condition** or hereditary condition (whether diagnosed as a **chronic condition** or not) and **treatment** for any **related condition**.

This benefit does not extend to mental health treatment, complementary medicine or traditional Chinese medicine.

There is no cover for **congenital conditions** or hereditary conditions if, prior to commencement of **your** cover, **you** have had any abnormal signs, symptoms or test results related to the **congenital condition** or hereditary condition (whether or not a specific diagnosis has been made).

The lifetime limit shown applies irrespective of the number of **congenital conditions** and hereditary conditions.

Newborn babies may be eligible for this benefit once the congenital conditions or hereditary conditions limits have been exhausted under the *maternity costs* section of the **table of benefits**.

<p>● <b>In-patient, day-patient and post-hospital treatment</b> received within the 90-day period following the date <b>you</b> are discharged from <b>hospital</b>, up to a lifetime limit of US\$20,000 or £13,300 or €15,000</p>	<p>● Lifetime limit of US\$20,000 or £13,300 or €15,000</p>	<p>● Lifetime limit of US\$40,000 or £26,600 or €30,000</p>	<p>● Lifetime limit of US\$80,000 or £53,300 or €60,000</p>
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### Mental health treatment

Important notes:

- You must obtain pre-authorization for all benefits in this section.
- All **treatment** must be administered under the direct control of a registered psychiatrist, psychologist or counsellor.
- We do not cover investigations or **treatment** related to phobias, hypnotherapy, postnatal depression or marriage/relationship counselling, or psycho-geriatric conditions including Alzheimer's disease or dementia.

#### Lifetime mental health treatment limit

The overall maximum limit to the amount that **you** can **claim** for all benefits in the *mental health treatment* section that are covered by **your plan** during **your** lifetime.

<p>US\$50,000 or £33,300 or €37,500</p>	<p>No cover</p>	<p>US\$75,000 or £50,000 or €56,250</p>	<p>US\$100,000 or £66,600 or €75,000</p>
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#### In-patient and day-patient mental health treatment (12-month waiting period)

**In-patient** and **day-patient treatment** received in a recognised mental health unit of a **hospital**.

<p>● Up to 30 days per period of cover</p>	<p>● No cover</p>	<p>● Up to 30 days per period of cover</p>	<p>● Up to 30 days per period of cover</p>
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Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

## Mental health treatment (continued)

Important notes:

- You must obtain pre-authorization for all benefits in this section.
- All **treatment** must be administered under the direct control of a registered psychiatrist, psychologist or counsellor.
- We do not cover investigations or **treatment** related to phobias, hypnotherapy, postnatal depression or marriage/relationship counselling, or psycho-geriatric conditions including Alzheimer's disease or dementia.

### Out-patient mental health treatment (12-month waiting period)

**Specialist** mental health consultations with a registered psychiatrist or psychologist or mental health consultations with a registered counsellor when you have been referred by a **medical doctor**.

We do not pay for drugs prescribed for **out-patient** mental health **treatment**.



Up to 10 consultations per **period of cover** for **post-hospital treatment** received within the 90-day period following the date you are discharged from **hospital**



No cover



Up to 10 consultations per **period of cover**



Up to 10 consultations per **period of cover**

## HIV/AIDS treatment

Important notes:

- You must obtain pre-authorization for all benefits in this section.

### (24-month waiting period)

**Treatment** arising from or related to Human Immunodeficiency Virus (HIV) and/or HIV-related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) for a maximum period of 5 years.

We do not provide cover if the virus was contracted before your **date of entry**.



**In-patient and day-patient treatment** only, up to US\$5,000 or £3,300 or €3,750 per **period of cover**



Up to US\$5,000 or £3,300 or €3,750 per **period of cover**



Up to US\$75,000 or £50,000 or €56,250 per **period of cover**



Up to US\$100,000 or £66,600 or €75,000 per **period of cover**

## Medical appliances

### Medical aids

Supplying, fitting or hiring instruments, apparatuses or devices which are medically prescribed as a medical aid to you (e.g. crutches, wheelchairs, orthopaedic supports/braces, orthotics, stoma supplies, compression stockings) when it immediately follows **in-patient, day-patient** or emergency ward **treatment** covered by your **plan**.

We do not cover medical aids that form part of the care of a **chronic condition**. We do not cover unprescribed medical aids such as gym equipment, even if you have been advised to use such an aid.



Up to US\$250 or £160 or €188 per medical condition per **period of cover**



No cover



Up to US\$500 or £330 or €375 per medical condition per **period of cover**



Up to US\$1,000 or £660 or €750 per medical condition per **period of cover**

### Prosthetic implants

Surgically-implanted, artificial body parts necessary to replace a joint or ligament, a heart valve, the aorta or an arterial blood vessel, a sphincter muscle, the lens or cornea of the eye, or to control urinary incontinence, or to act as a heart pacemaker, or to remove excess fluid from the brain.

As part of this benefit, we will also pay for a knee brace if it is an essential part of a surgical operation for the repair to a knee ligament, and for a spinal support if it is an essential part of a surgical operation to the spine.



Full cover



Full cover



Full cover



Full cover

## Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

## Bronze

## SilverLite

## Silver

## Gold

## Medical appliances (continued)

## Prosthetic devices

External prosthetic body parts, such as prosthetic limbs, fitted after the healing of an amputation covered by **your plan**.

Up to US\$500 or £330 or €375 per device

Up to US\$1,000 or £660 or €750 per device

Up to US\$1,000 or £660 or €750 per device

Up to US\$1,500 or £1,000 or €1,125 per device

## Out-patient treatment

Important notes:

- You must obtain pre-authorisation for certain benefits in this section.

## Annual limit for out-patient treatment

The overall maximum limit to the amount **you** can **claim** for **treatment you** receive as an **out-patient** during any one **period of cover**.

The annual limit for out-patient treatment option selected under the SilverLite **plan** will also be the option that applies to the primary medical care benefit. **You** are not eligible for additional cover if **you** do not select an option.

No annual limit

Up to US\$5,000 or £3,300 or €3,750 **per period of cover**

No annual limit

No annual limit

Option A Up to US\$7,500 or £5,000 or €5,625 **per period of cover**

Option B Up to US\$10,000 or £6,600 or €7,500 **per period of cover**

## Primary medical care

Visits to a GP or **doctor**, **specialist** consultations, prescribed drugs and dressings, pathology, scans, radiology and **diagnostic tests** received as an **out-patient**. **We** do not cover home visits.

The primary medical care option selected under the SilverLite **plan** will also be the option that applies to the annual limit for out-patient treatment. **You** are not eligible for additional cover if **you** do not select an option.

**Post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**

Up to US\$1,500 or £1,000 or €1,125 **per period of cover**

Option A Up to US\$2,500 or £1,665 or €1,875 **per period of cover**

Option B Up to US\$3,500 or £2,310 or €2,625 **per period of cover**

Full cover

Full cover

## Emergency ward treatment

**Emergency treatment** that **you** have received at a **hospital**.

Essential and immediate **treatment** necessary as the result of an **accident**, plus one follow-up appointment with a **medical doctor**

Up to the annual limit for **out-patient treatment**

Full cover

Full cover

## Out-patient surgical procedures

Surgical procedures where it is not **medically necessary** for **you** to be admitted to **hospital** as an **in-patient** or **day-patient**.

Full cover

Up to the annual limit for **out-patient treatment**

Full cover

Full cover

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

**Out-patient treatment (continued)**

Important notes:

- You must obtain pre-authorization for certain benefits in this section.

**Advanced diagnostic tests**

MRI and CAT (CT) scans performed on the advice of a **medical doctor** and PET scans performed on the advice of a **specialist**. **Your medical referral letter** will be required.

We will pay for one consultation only to obtain the results of the **diagnostic test**.

You must obtain pre-authorization for all advanced **diagnostic tests**.

Full cover

 Up to the annual limit for **out-patient treatment**

Full cover

Full cover

**Complementary treatments**

**Treatment** by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist on the advice of a **medical doctor**.

**Your medical referral letter** will be required for any **treatment** by a chiropractor, osteopath, chiropodist or podiatrist. If **your** condition is (or becomes) a **chronic condition** and ongoing **treatment** is aimed at maintaining it rather than curing it, no further payments will be made. Cover is limited to the maximum number of **sessions** shown per **period of cover** in respect of all **treatment** types. **Treatment** must be performed by a **medical practitioner**. Medication provided by complementary therapists is not covered under this benefit.

 Up to 10 **sessions** per **period of cover** for **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**

No cover

 Up to 10 **sessions** per **period of cover** Up to 15 **sessions** per **period of cover****Hormone replacement therapy**

When prescribed by a **medical doctor** following **your** diagnosis with premature ovarian failure (i.e. loss of ovarian function before the age of 40).

No cover

No cover

Maximum period of 12 months from the date of diagnosis

Maximum period of 18 months from the date of diagnosis

**Traditional Chinese medicine**

Cover is limited to the maximum number of **sessions** shown per **period of cover**. **Treatment** must be performed by a **medical practitioner**.

No cover

No cover

 Up to US\$50 or £33 or €38 per **session**, up to a maximum of 15 **sessions** Up to US\$50 or £33 or €38 per **session**, up to a maximum of 20 **sessions****Physiotherapy**

**Medically necessary** physiotherapy when **you** have been referred on the advice of **your medical doctor** to a physiotherapist who is registered to practice physiotherapy in the country where the **treatment** is administered. **You** must send **us your medical referral letter** in support of **your claim**.

After **your** first 6 **sessions** of physiotherapy, if **you** need more **sessions** **you** must contact **us** for pre-authorization. **We** will write to **your doctor** for a medical report in order to assess **your claim** further. After **your** first 6 **sessions**, **we** will not pay for any physiotherapy that **we** have not pre-authorized.

If **your** condition is (or becomes) a **chronic condition** and ongoing **treatment** is aimed at maintaining rather than curing it, no further payments will be made.

**Post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**, up to US\$1,000 or £660 or €750 per **period of cover** Up to US\$250 or £165 or €188 per **period of cover** up to the annual limit for **out-patient treatment**

Full cover

Full cover

Key ● Full cover within annual benefit limit ● Partial or limited cover ● No cover ● Optional cover

Bronze	SilverLite	Silver	Gold
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### Chronic conditions

#### Acute flare-ups

Short-term **treatment** to treat acute flare-ups of a **chronic condition** covered by **your plan**.

Bronze	SilverLite	Silver	Gold
<span style="color: orange;">●</span> <b>In-patient, day-patient, and post-hospital treatment</b> received within the 90-day period following the date <b>you</b> are discharged from <b>hospital</b>	<span style="color: orange;">●</span> <b>In-patient and day-patient treatment</b> , with cover for <b>out-patient treatment</b> up to the benefit limit for primary medical care	<span style="color: green;">●</span> Full cover	<span style="color: green;">●</span> Full cover

#### Monitoring and maintenance

Regular consultations, tests, and prescribed medication required to monitor and maintain the stability of a **chronic condition**.

Bronze	SilverLite	Silver	Gold
<span style="color: red;">●</span> No cover	<span style="color: orange;">●</span> Up to the benefit limit for primary medical care	<span style="color: green;">●</span> Full cover	<span style="color: green;">●</span> Full cover

### Well-being benefits

Important notes:

- You** are eligible for certain benefits in this section only if **you** have selected them and they are stated on **your Certificate of Insurance**.

#### Preventive health and well-being (6-month waiting period)

**Preventive health checks** and tests for adults, including:

- health screens (e.g. tests for cholesterol, high blood pressure, diabetes, anaemia, lung/kidney/liver function, cardiac risk)
- Papanicolaou (PAP) test
- mammogram, prostate cancer, and colon cancer screens
- flu jabs
- hearing test
- eye examination

If **you** have selected the enhanced preventive health and well-being option, **you** are eligible for the higher benefit limit on **your plan**.

Bronze	SilverLite	Silver	Gold
<span style="color: red;">●</span> No cover	<span style="color: red;">●</span> No cover	<span style="color: orange;">●</span> Up to US\$300 or £200 or €225 per <b>period of cover</b>	<span style="color: orange;">●</span> Up to US\$750 or £500 or €563 per <b>period of cover</b>
		<span style="color: blue;">●</span> Up to US\$500 or £330 or €375 per <b>period of cover</b> (if <b>you</b> have selected the enhanced option)	<span style="color: blue;">●</span> Up to US\$1,300 or £860 or €975 per <b>period of cover</b> (if <b>you</b> have selected the enhanced option)

#### Vaccinations for adults

Immunisations and booster injections required under regulation of the country in which **treatment** is being given, and any **medically necessary** travel vaccinations and malaria prophylaxis.

Bronze	SilverLite	Silver	Gold
<span style="color: red;">●</span> No cover	<span style="color: red;">●</span> No cover	<span style="color: orange;">●</span> Up to US\$150 or £100 or €113 per <b>period of cover</b>	<span style="color: orange;">●</span> Up to US\$250 or £167 or €188 per <b>period of cover</b>

#### Well-child benefit (6-month waiting period)

Routine vaccinations and developmental check-ups for children.

Vaccinations are limited to all basic immunisations and booster injections that are either mandated, or part of government recommended programmes within the country in which they are administered.

6-month waiting period will be waived if either parent has been insured on the **plan** for at least 6 months when children are added to the **plan**.

Bronze	SilverLite	Silver	Gold
<span style="color: red;">●</span> No cover	<span style="color: red;">●</span> No cover	<span style="color: orange;">●</span> Up to US\$200 or £133 or €150 per <b>period of cover</b>	<span style="color: orange;">●</span> Up to US\$400 or £260 or €300 per <b>period of cover</b>



Key

- Full cover within annual benefit limit    
 ● Partial or limited cover    
 ● No cover    
 ● Optional cover

Bronze	SilverLite	Silver	Gold
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### Rehabilitation treatment

Important notes:

- You must obtain pre-authorisation for all benefits in this section.

Rehabilitation treatment you receive as an **in-patient**, carried out under the control and supervision of a **specialist** in a recognised **rehabilitation hospital or unit**, and only when it immediately follows **in-patient treatment** for illness or injury covered by **your plan**.

● Up to 7 days per medical condition	● Up to 7 days per medical condition	● Up to 15 days per medical condition	● Up to 30 days per medical condition
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This benefit is payable only when the admission takes place on the written recommendation of **your treating specialist** and the admission must take place immediately following **your discharge from hospital**.

### Home nursing costs

Important notes:

- You must obtain pre-authorisation for all benefits in this section.

The medical services of a **qualified nurse** to treat **you in your own home** when it is **medically necessary** and relates directly to an illness or injury covered by **your plan**.

● Up to 12 weeks per medical condition	● Up to 2 weeks per medical condition	● Up to 12 weeks per medical condition	● Up to 12 weeks per medical condition
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### Lifetime care

Important notes:

- You must obtain pre-authorisation for all benefits in this section.

#### Lifetime limit for all lifetime care

The overall maximum limit to the amount that **you can claim** for all benefits in the **lifetime care** section that are covered by **your plan** during **your lifetime**.

US\$25,000 or £16,600 or €18,750	US\$50,000 or £33,300 or €37,500	US\$50,000 or £33,300 or €37,500	US\$100,000 or £66,600 or €75,000
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#### Hospice and palliative care

On diagnosis of a **terminal medical condition** covered by **your plan**, all costs for **treatment** received on the advice of a **medical practitioner** or **specialist** for the purpose of offering relief of symptoms. This includes all **hospital** or hospice accommodation, and nursing care by a **qualified nurse**.

● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care
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#### Artificial life maintenance

Treatment you require after you have already been on **artificial life maintenance** for 8 weeks.

● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care
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#### Persistent vegetative state and neurological damage

Treatment you require after you have been in **hospital** for 8 weeks for permanent neurological damage or if you are in a persistent **vegetative state**.

● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care	● Up to the lifetime limit for all lifetime care
--	--	--	--

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

## Dental costs

Important notes:

- You are eligible for certain benefits in this section only if you have selected them and they are stated on your **Certificate of Insurance**.
- All **dental treatment** must be carried out by a **dentist** in a **hospital** emergency room or dental surgery.
- **Treatment** for damaged crowns, dentures, bridge work or false teeth is only covered under the Dental Plus benefit.
- We do not cover orthodontic consultations or **treatment** of any kind.

### Emergency restorative treatment you receive as an in-patient

**In-patient treatment** required to restore sound and natural teeth following an **accident** covered by your **plan**, provided that **treatment** is received within 15 days of the **accident**.

Full cover

Up to US\$5,000 or £3,330 or €3,750 per **period of cover**

Full cover

Full cover

### Emergency restorative treatment you receive as an out-patient

**Out-patient treatment** required to treat or replace sound and natural teeth which are lost or damaged following an **accident**, provided that **treatment** is received within 72 hours of the **accident**.

No cover

No cover

Up to US\$500 or £330 or €375 per **period of cover**

Up to US\$1,000 or £660 or €750 per **period of cover**

### Dental Basic (6-month waiting period)

We will pay for the following basic dental costs:

- screening (e.g. the checking for and/or the assessment of any diseased, missing and filled teeth including X-rays where necessary) twice per year
- scaling and polishing and sealing (twice per year)
- fillings (both composite and amalgam)
- simple extractions
- root canal **treatment**

The Dental Basic benefit is optional on the Silver **plan**. It is included as standard on the Gold **plan**.

No cover

Up to US\$500 or £330 or €375 per **period of cover**, subject to a 20% **co-insurance** (if you have selected the Dental Basic option)

Up to US\$1,000 or £660 or €750 per **period of cover**, subject to a 20% **co-insurance** (if you have selected the Dental Basic option)

Up to US\$1,500 or £1,000 or €1,125 per **period of cover**

### Dental Plus (12-month waiting period)

We will pay for the following advanced dental costs:

- denture repair
- full/partial dentures
- dental bridges
- crowns, inlays, and onlays
- dental implants

This benefit is optional on the Silver and Gold **plans**. Silver **plan holders** wishing to select Dental Plus must also select the Dental Basic option

No cover

No cover

Up to US\$1,500 or £1,000 or €1,125 per **period of cover**, subject to a 20% **co-insurance** (if you have selected the Dental Plus option)

Up to US\$2,000 or £1,330 or €1,500 per **period of cover**, subject to a 20% **co-insurance** (if you have selected the Dental Plus option)

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

## Maternity costs

Important notes:

- Dependant children included in **your plan** are not eligible for these benefits.
- You must obtain pre-authorisation for all benefits in this section.
- We do not cover the **treatment** of any newborn child born following **assisted reproduction** (e.g. IVF) in the event of the birth occurring within 36 weeks of conception.
- Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and childbirth benefit.
- We do not cover pregnancy testing, or pre-natal classes and doulas.
- We do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy.
- We do not cover breast pumps.

### Routine maternity care and routine care of newborns (12-month waiting period)

No cover

No cover

No cover

Up to US\$15,000 or £10,000 or €11,250 per pregnancy

We will pay for the following routine maternity costs:

- pre-natal tests and examinations
- post-natal **treatments** and examinations
- natural childbirth
- childbirth by **planned caesarean section**
- any **hospital** accommodation costs for the newborn baby
- basic newborn healthcare (physical examination, vitamin K, hepatitis B vaccine, BCG vaccine, one hearing test, blood tests for PKU, congenital hypothyroidism and G6PD, prior to discharge from the **hospital**)
- home birth, where a midwife is present
- supplements and vitamins as recommended by a **medical doctor**

The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. Any **hospital** or birthing center accommodation costs will be limited to the cost of a standard **hospital** room.

### Complications of pregnancy (12-month waiting period)

Up to US\$4,800 or £3,200 or €3,600 per period of cover

Up to US\$10,000 or £6,600 or €7,500 per period of cover

Up to US\$15,000 or £10,000 or €11,250 per period of cover

Full cover

In-patient or day-patient treatment necessary as a direct result of a **complication of pregnancy**.

We do not provide cover for childbirth under this benefit.

We do not provide cover under this benefit for complications arising from a pregnancy established through **assisted reproduction** (e.g. IVF) until after the standard 12-week scan, irrespective of how long **you** have been covered by **your plan**.

### Childbirth necessitating an emergency surgical procedure (12-month waiting period)

No cover

No cover

No cover

Full cover

Surgeons', anaesthetists' and theatre fees for childbirth that necessitates an emergency surgical procedure and any additional accommodation charges incurred as the result of the surgical procedure. This includes childbirth by **emergency caesarean section**.

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

## Maternity costs (continued)

Important notes:

- Dependant children included in **your plan** are not eligible for these benefits.
- **You** must obtain pre-authorisation for all benefits in this section.
- **We** do not cover the **treatment** of any newborn child born following **assisted reproduction** (e.g. IVF) in the event of the birth occurring within 36 weeks of conception.
- Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and childbirth benefit.
- **We** do not cover pregnancy testing, or pre-natal classes and doulas.
- **We** do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy.
- **We** do not cover breast pumps.

### Treatment for congenital conditions or hereditary conditions for newborn babies

Treatment that **your newborn** receives for a **congenital condition** or hereditary condition (whether diagnosed as a **chronic condition** or not) and treatment for any **related condition**.

This benefit is subject to the following conditions:

- **Your newborn** must be added to **your plan** within 30-days of birth and premiums paid
- **Your newborn** baby must have the same **plan** as **you**
- Either parent must have been insured on a Silver or Gold **plan** for a minimum of 12 months prior to the birth

The limits shown apply to each pregnancy, regardless of the number of children born.

No cover

No cover

**In-patient or day-patient treatment** received within the 90-day period following birth, up to US\$10,000 or £6,600 or €7,500 per pregnancy

 **In-patient or day-patient treatment** received within the 90-day period following birth, up to US\$100,000 or £66,600 or €75,000 per pregnancy

## Expat benefits

Important notes:

- **You** are eligible for certain benefits in this section only if **you** have selected them and they are stated on **your Certificate of Insurance**.
- **You** must obtain pre-authorisation for all benefits in this section.

### 24-hour medical assistance helpline

If **you** have a medical emergency which requires immediate medical assistance, **you** must contact **our** 24-hour helpline (provided by CEGA) at +44 (0) 1243 621 155 or [william.russell@cegagroup.com](mailto:william.russell@cegagroup.com).

Full cover

Full cover

Full cover

Full cover

### Medevac Basic

If **you** (or any child covered by the newborn benefit within its first 90 days of life) have a life-threatening or limb-threatening condition covered by **your plan** which requires immediate **in-patient treatment** that cannot be adequately provided locally, the **Assistance Service** will arrange for **you** to be moved by air and/or by surface transportation to the nearest **hospital** within **your area of cover** where appropriate medical **treatment** is available.

**We** do not cover any other costs under this benefit such as hotel accommodation charges. **We** do not cover emergency evacuation to, from or within the United States of America. The **Assistance Service** retains the absolute right to decide whether **your** medical condition is eligible for evacuation, where **you** are evacuated to, and the means and method of the evacuation.

Full cover

Full cover

Full cover

Full cover

## Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

## Bronze

## SilverLite

## Silver

## Gold

## Expat benefits (continued)

Important notes:

- You are eligible for certain benefits in this section only if you have selected them and they are stated on your Certificate of Insurance.
- You must obtain pre-authorisation for all benefits in this section.

## Return airfare

Full cover

Full cover

Full cover

Full cover

Following an emergency evacuation covered by your plan, we will pay for your economy return airfare to your country of residence.

## Travel expenses of a companion

Full cover

Full cover

Full cover

Full cover

The transportation costs of another person to accompany you on your emergency evacuation, and their economy-class ticket back. If it is not possible for them to accompany you on your medical evacuation because of the method of evacuation, we will pay either for their economy-class round-trip airfare on a scheduled flight, or their suitable round-trip surface transportation, whichever is the most appropriate.

## Accommodation expenses of a companion

Up to US\$72 or £48 or €54 per night

Up to US\$50 or £33 or €38 per night

Up to US\$96 or £64 or €72 per night

Up to US\$250 or £167 or €188 per night

If your companion is then staying with you while you are hospitalised following your emergency evacuation, we will pay towards the costs of their hotel accommodation (limited to a maximum of 15 nights per period of cover).

## Compassionate home visit (12-month waiting period)

Lifetime limit of one claim per insured person

No cover

Lifetime limit of one claim per insured person

Lifetime limit of one claim per insured person

If a close family member dies during your period of cover and after you have been insured by your plan for a continuous period of 12 months, we will pay for your economy-class round-trip airfare to attend the funeral. Your travel must take place within 28 days of the date of death.

## Repatriation of mortal remains

Full cover

Up to US\$5,000 or £3,330 or €3,750

Full cover

Full cover

If you die as the result of a condition that is covered by your plan while you are outside your country of nationality, we will pay for your body or ashes to be transported to your country of nationality or country of residence. This benefit is not available if a claim is made for the burial or cremation benefit at the place where you died.

## Burial or cremation

Up to US\$1,600 or £1,060 or €1,200

Up to US\$1,600 or £1,060 or €1,200

Up to US\$1,600 or £1,060 or €1,200

Up to US\$1,600 or £1,060 or €1,200

If you die as the result of a condition that is covered by your plan while you are outside your country of nationality, we will pay for you to be buried or cremated at the place where you died.

This benefit is not available if a claim is made under the repatriation of mortal remains benefit. We do not provide cover under this benefit if you die in your country of nationality. We do not provide cover under this benefit for the costs of a religious practitioner.

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

### Expat benefits (continued)

Important notes:

- You are eligible for certain benefits in this section only if you have selected them and they are stated on your Certificate of Insurance.
- You must obtain pre-authorisation for all benefits in this section.

#### Medevac Plus

The following benefits apply in addition to those under the Medevac Basic benefit.

Evacuation if you (or any child covered by the newborn benefit within its first 90 days of life) need **advanced diagnostics** or cancer **treatment** such as radiotherapy or chemotherapy that cannot be adequately provided locally.

All eligible evacuations will include repatriation to **your country of nationality** if it is within **your area of cover**, or to **your country of residence**. We do not cover emergency evacuation or repatriation to, from or within the United States of America.

If you request repatriation to **your country of nationality** or to **your country of residence**, it may, in some cases, not be appropriate immediately due to **your** medical condition. In such cases, we will first evacuate you to the nearest place within **your area of cover** where appropriate **treatment** is available. Once you have been stabilised, we will then repatriate you to **your country of nationality** if it is within **your area of cover**, or **your country of residence**.

If you are evacuated to a country which is not **your country of residence** and not **your country of nationality**, and you do not have anyone to accompany you, we will pay the economy-class round-trip airfare to have one companion flown from anywhere in the world to be with you while you receive **your treatment**. We will also pay up to US\$150 per day (for a maximum of 30 days per **period of cover**) towards their hotel accommodation expenses whilst you have **your treatment**, or until the date on which you return to your **country of nationality** or your **country of residence** (whichever is the sooner).

The Medevac Plus benefit is optional on all plans.

Full cover (if you have selected the Medevac Plus option)

Full cover (if you have selected the Medevac Plus option)

Full cover (if you have selected the Medevac Plus option)

Full cover (if you have selected the Medevac Plus option)