Table of Benefits

The following table of benefits sets out the cover provided by each plan type. The plan type 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.

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 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 your employer has 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-authorisation. If you do not obtain pre-authorisation we will only pay 80% of the reasonable and customary costs of treatment.

This table of benefits should be read in conjunction with your plan agreement.

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

	Bronze	Silver	Gold
Annual benefit limit The overall maximum limit that each insured person can claim during any one period of cover.	US$1,500,000	US$2,500,000	US$5,000,000
Hospital costs Important notes: • You must obtain pre-authorisation for all benefits in this section.			
Hospital accommodation Private hospital room - the cost of a standard single room with an en-suite bath or shower room, when you are an in-patient or day-patient.	○ Full cover	○ Full cover	○ Full cover
Hospital treatment Treatment you receive while you are an in-patient or day-patient, including surgeons' and anaesthetists' and doctors' fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, diagnostic tests and physiotherapy. We will also pay for pre-admission tests that you undergo on an out-patient basis for hospital treatment you are scheduled to receive that is covered by your plan. We will also pay for in-patient or day-patient surgical removal of impacted, buried or unerupted wisdom teeth. This is subject to a 12-month waiting period and covered only when the surgery is performed by a medical doctor (not a dentist) in a hospital (not a dental surgery) and under general anaesthetic.	○ Full cover	○ Full cover	○ Full cover

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

	Bronze	Silver	Gold
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
Road ambulance The cost of a private road ambulance if you need hospital treatment covered by your plan and if it is medically necessary for you to travel to hospital by ambulance.	Full cover	Full cover	Full cover
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 per night	US$200 per night	US$250 per night
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
Cancer genome tests The cost of tests to sequence the genes of cancer cells.	Up to US$6,000 period of cover	Up to US$6,000 per period of cover	Up to US$6,000 per period of cover
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	US$5,000 with a lifetime limit of one claim per insured person

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

	Bronze	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.	Lifetime limit of US$150	Lifetime limit of US$150	Lifetime limit of US$150
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.	Lifetime limit of US$500	Lifetime limit of US$500	Lifetime limit of US$500
Dietitian Consultation with a registered dietitian when you have received cancer treatment covered by your plan, up to a lifetime limit of 2 consultations.	Lifetime limit of US$100	Lifetime limit of US$100	Lifetime limit of US$100
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
Donor costs Medical costs associated with the donor as an in-patient or day-patient.	Up to US$25,000 per transplant	Up to US$25,000 per transplant	Up to US$25,000 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

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

	Bronze	Silver	Gold
Reconstructive surgery Important notes: • You must obtain pre-authorisation 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.	In-patient, day-patient and post-hospital treatment received within the 90-day period following the date you are discharged from hospital	Full cover	Full cover
Congenital conditions or hereditary conditions Important notes: • You must obtain pre-authorisation 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.	In-patient, day-patient and post-hospital treatment received within the 90-day period following the date you are discharged from hospital, up to a lifetime limit of US$20,000	Lifetime limit of US$40,000	Lifetime limit of US$80,000
Mental health treatment Important notes: • You must obtain pre-authorisation 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.	US$50,000	US$75,000	US$100,000
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**.	Up to 30 days per **period of cover**	Up to 30 days per **period of cover**	Up to 30 days per **period of cover**

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

	Bronze	Silver	Gold
Mental health treatment (continued) Important notes: • You must obtain pre-authorisation 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.	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	Up to 10 consultations per period of cover	Up to 10 consultations per period of cover
Out-patient mental health medication (12-month waiting period) Medication prescribed by a medical doctor or registered psychiatrist to treat a mental health condition.	Up to US$500 per period of cover, subject to a 20% co-insurance, per period of cover for post-hospital treatment received within the 90-day period following the date you are discharged from hospital	Up to US$500 per period of cover, subject to a 20% co-insurance	Up to US$500 per period of cover, subject to a 20% co-insurance
HIV/AIDS treatment Important notes: • You must obtain pre-authorisation 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 per period of cover	Up to US$75,000 per period of cover	Up to US$100,000 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 per medical condition per period of cover	Up to US$500 per medical condition per period of cover	Up to US$1,000 per medical condition per period of cover

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

	Bronze	Silver	Gold
Medical appliances (continued)			
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
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 per device	Up to US$1,000 per device	Up to US$1,500 per device
Out-patient treatment A Important notes: • You must obtain pre-authorisation for certain benefits in this section if your medical treatment costs will exceed US$500.			
Annual limit for benefits in this section The overall maximum limit to the amount you can claim for treatment for the benefits in this section during any one period of cover.	US$4,000 per period of cover	No annual limit	No annual limit
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.	**Post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**	Full cover	Full cover
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-authorisation for all advanced diagnostic tests.	Full cover	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	Up to 10 sessions per period of cover	Up to 15 sessions per period of cover

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

	Bronze	Silver	Gold
Out-patient treatment A (continued) Important notes: • You must obtain pre-authorisation for certain benefits in this section if your medical treatment costs will exceed US$500.			
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-authorisation. 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-authorised. 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 period of cover	Full cover	Full cover
Out-patient treatment B Important notes: • You must obtain pre-authorisation for certain benefits in this section if your medical treatment costs will exceed US$500.			
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	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	Full cover	Full 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	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	Up to US$50 per session, up to a maximum of 15 sessions	Up to US$50 per session, up to a maximum of 20 sessions

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

	Bronze	Silver	Gold
Chronic conditions			
Acute flare-ups Short-term treatment to treat acute flare-ups of a chronic condition covered by your plan.	In-patient, day-patient, and post-hospital treatment received within the 90-day period following the date you are discharged from hospital	Full cover	Full cover
Monitoring and maintenance Regular consultations, tests, and prescribed medication required to monitor and maintain the stability of a chronic condition.	No cover	Full cover	Full cover
Well-being benefits Important notes: • You are eligible for certain benefits in this section only if your employer has 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 your employer has selected the enhanced preventive health and well-being option, you are eligible for the higher benefit limit on your plan.	No cover	Up to US$300 per period of cover Up to US$500 per period of cover (only if selected by your employer)	Up to US$750 per period of cover Up to US$1,300 per period of cover (only if selected by your employer)
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.	No cover	Up to US$150 per period of cover	Up to US$250 per period of cover
Well-child benefit (12-month waiting period) Routine vaccinations and developmental check-ups for children.	No cover	Up to US$200 per period of cover	Up to US$400 per period of cover

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

	Bronze	Silver	Gold
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. 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.	Up to 7 days per medical condition	Up to 15 days per medical condition	Up to 30 days per medical condition
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 12 weeks per medical condition	Up to 12 weeks per medical condition
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	US$50,000	US$100,000
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
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
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

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

	Bronze	Silver	Gold
Optical care Important notes: • You are eligible for certain benefits in this section only if your employer has selected them and they are stated on your Certificate of Insurance.			
We will pay for an annual optical test and for lenses, frames and contact lenses upon a change of prescription within this benefit. We do not pay for LASIK eye surgery or any other surgical correction of short-sightedness (myopia), long-sightedness (hyperopia) or irregular-shaped cornea (astigmatism). You are eligible for the optical care benefit only if it has been selected by your employer.	No cover	Up to US$200 per period of cover (only if selected by your employer)	Up to US$200 per period of cover (only if selected by your employer)
Dental costs Important notes: • You are eligible for certain benefits in this section only if your employer has 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	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	Up to US$500 per period of cover	Up to US$1,000 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 on the Silver plan is limited to US$1,000 or US$1,500, depending on which option your employer has selected. You are not eligible for cover if neither option is selected.	No cover	**Option A** Up to US$1,000 per period of cover, subject to a 10% co-insurance (only if selected by your employer) — **Option B** Up to US$1,500 per period of cover, subject to a 10% co-insurance (only if selected by your employer)	Up to US$1,500 per period of cover

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

	Bronze	Silver	Gold
Dental costs (continued) Important notes: • You are eligible for certain benefits in this section only if your employer has 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.			
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 You are eligible for the Dental Plus benefit only if it has been selected by your employer.	No cover	Up to US$1,500 per period of cover, subject to a 10% co-insurance (only if selected by your employer)	Up to US$2,000 per period of cover, subject to a 10% co-insurance (only if selected by your employer)
Maternity costs Important notes: • You are eligible for certain benefits in this section only if your employer has selected them and they are stated on your Certificate of Insurance. • 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) 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.	No cover	**Option A** Up to US$5,000 per pregnancy, subject to a 20% co-insurance (only if selected by your employer) ——— **Option B** Up to US$7,500 per pregnancy, subject to a 20% co-insurance (only if selected by your employer) ——— **Option C** Up to US$10,000 per pregnancy, subject to a 20% co-insurance (only if selected by your employer)	Up to US$15,000 per pregnancy

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

Maternity costs (continued)

Important notes:

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

	Bronze	Silver	Gold
Complications of pregnancy (12-month waiting period) 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.	Up to US$4,800 per period of cover	Up to US$15,000 per period of cover Full cover (only if selected by your employer)	Full cover
Childbirth necessitating an emergency surgical procedure (12-month waiting period) 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.	No cover	Up to US$20,000 per pregnancy (only if selected by your employer)	Full cover
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 eligible dependants must be covered under your employer's Silver or Gold plan ▪ Your newborn must be added to your plan within 30-days of birth and premiums paid ▪ Either parent must have been insured on your employer's Silver or Gold plan for a minimum of 12 months The limits shown apply to each pregnancy, regardless of the number of children born. The benefit limit on the Silver plan is extended if the complex maternity option is selected by your employer.	No cover	In-patient or daypatient treatment received within the 90-day period following birth, up to US$10,000 per pregnancy In-patient or daypatient treatment received within the 90-day period following birth, up to US$50,000 per pregnancy (only if selected by your employer)	In-patient or daypatient treatment received within the 90-day period following birth, up to US$100,000 per pregnancy

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

	Bronze	Silver	Gold
Expat benefits (continued) Important notes: • You are eligible for certain benefits in this section only if your employer has 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 Fullerton Health) at +62 21 2997 6365 or williamrussell@fullertonhealth.com or case.managers@fullertonhealth.com.	Full cover	Full cover	Full cover
Medevac Basic If you 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
Return airfare Following an emergency evacuation covered by your plan, we will pay for your economy return airfare to your country of residence.	Full cover	Full cover	Full cover
Travel expenses of a companion 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.	Full cover	Full cover	Full cover
Accommodation expenses of a companion 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).	Up to US$72 per night	Up to US$96 per night	Up to US$250 per night
Compassionate home visit (12-month waiting period) 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.	Lifetime limit of one claim per insured person	Lifetime limit of one claim per insured person	Lifetime limit of one claim per insured person

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

	Bronze	Silver	Gold
Expat benefits (continued) Important notes: • You are eligible for certain benefits in this section only if your employer has selected them and they are stated on your Certificate of Insurance. • You must obtain pre-authorisation for all benefits in this section.			
Repatriation of mortal remains 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.	Full cover	Full cover	Full cover
Burial or cremation 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.	Up to US$1,600	Up to US$1,600	Up to US$1,600
Medevac Plus The following benefits apply in addition to those under the Medevac Basic benefit. Evacuation if you 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 (only if selected by your employer)	Full cover (only if selected by your employer)	Full cover (only if selected by your employer)

The international health insurance plans are insured and issued by PT Lippo General Insurance Tbk, a company registered & administered by Otoritas Jasa Keuangan. The plans are designed by William Russell Ltd, a company authorised & regulated in the UK by the FCA, reference number 309314.

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