

Your coverage zone

The cover provided by **your** policy is limited to within the **coverage zone** stated on **your certificate of insurance**.

When **we** use the term '**emergency treatment**' throughout this **agreement**, **we** mean **treatment**:

- that is covered by **your plan**;
- that is immediately required if **you** suffer an **accident**, or if **you** suffer a sudden and unforeseen illness that **you** have never suffered from before;
- that is not for a **pre-existing medical condition**; and
- that is not for a condition for which **you** have a **personal medical exclusion**.

Please also note that even if **your** policy gives **you** cover in the USA, **we** do not cover emergency medical evacuations to, from, or within the USA.

Zone 1

Worldwide cover, with restricted cover in the USA.

You have cover in the USA during **temporary trips** of up to 45 days' duration from the date on which **you** enter the USA.

While in the USA, **you** have cover for **emergency treatment** only up to US\$50,000 or £33,000 or €37,500 per **policy year**.

There's no limit to the number of **temporary trips** **you** can make to the USA.

Zone 2

Worldwide cover (excluding the USA), but with restricted cover in the following countries and regions:

*United Kingdom, all countries in the European Economic Area, Andorra, the Channel Islands, Gibraltar, Greenland, Monaco, San Marino, Switzerland, the UAE, Singapore, Thailand (here, **your** cover is restricted only for **treatment you** receive at the Bumrungrad Hospital, Bangkok Hospital Group, and Samitivej Hospital facilities), China, Hong Kong, Macau, Taiwan, Japan, Australia, New Zealand, Canada, and the **Caribbean countries and islands**.*

While in any of the above countries or regions **you** have cover for **emergency treatment** only, up to US\$100,000 or £66,000 or €75,000 per **policy year**.

You have no cover at all in the USA.

Zone 3

Worldwide cover (excluding the USA), but with restricted cover in the following countries and regions:

*China, Hong Kong, Macau, Taiwan, Japan, Singapore, Switzerland, and the **London area**.*

While in any of the above countries or regions **you** have the following cover:

- 80% cover for elective, eligible **treatment** costs; and
- 100% cover for **emergency treatment** that **you** receive while on a **temporary trip** of up to 90 days' duration, up to US\$100,000 or £66,000 or €75,000 per **policy year**.

Zone 3 is only available if **your country of residence** is Indonesia.

Zone 4

Full cover in **Africa** and the **Indian Subcontinent**.

While outside of **Africa** and the **Indian Subcontinent** **you** have cover for **emergency treatment** only, up to US\$100,000 or £66,000 or €75,000 per **policy year**.

You have no cover at all in the USA.

Zone 5

Full cover in **Africa** (except South Africa) and the **Indian Subcontinent**.

While outside of **Africa** or the **Indian Subcontinent** (or while in South Africa) **you** have cover for **emergency treatment** only, up to US\$100,000 or £66,000 or €75,000 per **policy year**.

You have no cover at all in the USA.

Zone 6

This **coverage zone** is not available with **your** policy.

Zone 7

You have full cover in Brunei, Cambodia, Timor Leste, Indonesia, Laos, Malaysia, Myanmar, Papua New Guinea, the Philippines, and Vietnam, but no cover anywhere else.

Additional cover in the USA

If **you** have a USA cover option, **you** will see it stated on **your certificate of insurance**.

USA-45

You have cover in the USA for **temporary trips** of up to 45 days' duration from the date on which **you** enter the country. **Your** cover ends when a trip exceeds 45 days' duration.

While in the USA, **you** have cover for eligible **treatment** and care up to US\$250,000 per **policy year**. Within this amount, **you** have the following cover:

- up to US\$100,000 for elective, eligible **treatment** and care costs
- up to US\$250,000 for **emergency treatment**

There's no limit to the number of **temporary trips** **you** can make to the USA.

USA-90

You have cover in the USA for **temporary trips** of up to 90 days' duration from the date on which **you** enter the country. **Your** cover ends when a trip exceeds 90 days' duration.

While in the USA, **you** have cover for eligible **treatment** and care up to US\$250,000 per **policy year**. This amount includes elective **treatment, care** and **emergency treatment** that **you** receive.

There's no limit to the number of **temporary trips** **you** can make to the USA.

This option is only available to existing **members** who already have it on their policy.

What you are 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 full refund of **reasonable and customary** charges, less any **excess** or **co-insurance** applicable to **your policy**, 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-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
Annual benefit limit	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

Annual benefit limit

The overall maximum limit that each **member** can **claim** during any one **policy year**.

Hospital costs

Important notes:







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

Hospital accommodation

With cover for a private hospital room, we will pay the cost of a standard single room with an en-suite bath or shower room when you are an **inpatient** or **daypatient**.

With cover for a semi-private hospital room, we will pay the cost of a standard shared room with an en-suite bath or shower room when you are an **inpatient** or **daypatient**.

Accommodation in a private hospital room is only available under the Bronze and SilverLite plans if **your employer** has selected this option.

 Semi-private hospital room	 Semi-private hospital room	 Private hospital room	 Private hospital room
 Private hospital room	 Private hospital room		

Hospital treatment

Treatment you receive while you are an **inpatient** or **daypatient**, including surgeons' and anaesthetists' and **doctors'** fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, **imaging tests** and physiotherapy. We will also pay for **pre-admission tests** that you undergo on an **outpatient** basis for **hospital treatment** you are scheduled to receive that is covered by **your plan**.

We will also pay for the **inpatient** 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 **doctor** (not a dentist) in a **hospital** (not a dental surgery) and under general anaesthetic.

 Full cover	 Full cover	 Full cover	 Full cover
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Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

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

Full cover

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 **policy year**

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** to **us**. Benefit is paid for up to a maximum of 60 nights per **policy year**.

If **you** have an **excess**, we will not apply it 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

Advanced imaging tests

MRI and CAT (CT) scans performed on the advice of a **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 **imaging test**.

Full cover

Full cover

Full cover

Full cover

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

Cancer genome tests

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

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

Cancer treatment (continued)

Important notes:

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

Genetic testing for cancer (12-month waiting period)

No cover

No cover

Lifetime limit of US\$2,000 or £1,320 or €1,500

Lifetime limit of US\$4,000 or £2,640 or €3,000

We will pay for genetic tests (and any associated genetic counselling) for BRCA1 and BRCA2 genes (for breast, ovarian, prostate, and pancreatic cancer) and familial adenomatous polyposis (FAP) (for colorectal cancer).

We will only pay for such genetic tests if:

- your doctor has referred you; or
- you have a parent, sibling, or child with breast cancer or FAP, or their genetic testing has established the presence of a hereditary cancer syndrome; or
- tests take place outside of the USA.

We won't pay for genetic tests when similar tests are available free of charge in the public healthcare system of the country where you're receiving oncology treatment.

Preventive cancer treatment (12-month waiting period)

No cover

No cover

Lifetime limit of US\$25,000 or £16,600 or €18,750, subject to a 20% co-insurance

Lifetime limit of US\$40,000 or £26,600 or €30,000

We will only pay for mastectomy (surgery to remove breasts), oophorectomy (surgery to remove ovaries), and colectomy (surgery to remove all or part of the bowel).

We will only pay for these surgeries if:

- your doctor has referred you; or
- you have a parent, sibling, or child with a disease that's part of a hereditary cancer syndrome (e.g., breast cancer, ovarian cancer), or their genetic testing has established the presence of a hereditary cancer syndrome; or
- treatment takes place outside of the USA.

We won't pay for such surgeries when they are available free of charge in the public healthcare system of the country where you're receiving oncology treatment.

Cash benefit upon diagnosis of cancer (6-month waiting period)

No cover

No cover

No cover

US\$5,000 or £3,330 or €3,750 with a lifetime limit of one claim per member

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.

Wigs

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

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

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

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

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

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.

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 **doctor** for **outpatient** mental health **treatment** are covered under this benefit.

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

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

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

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.

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

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

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

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 **outpatient 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 **inpatient** or **daypatient**.

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

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

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

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 **inpatient**, **daypatient** or **outpatient**.

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

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.

Inpatient, daypatient and post-hospital treatment received within the 90-day period following the date **you** are discharged from **hospital** following reconstructive surgery

Full cover

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 **your date of entry**, **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**.

Inpatient, daypatient 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\$50,000 or £33,300 or €37,500

Lifetime limit of US\$60,000 or £40,000 or €45,000

Lifetime limit of US\$80,000 or £53,300 or €60,000

Lifetime limit of US\$100,000 or £66,600 or €75,000

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**.

Inpatient and daypatient treatment only, up to US\$5,000 or £3,300 or €3,750 per **policy year**

Up to US\$5,000 or £3,300 or €3,750 per **policy year**

Up to US\$75,000 or £50,000 or €56,250 per **policy year**

Up to US\$100,000 or £66,600 or €75,000 per **policy year**

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

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 or £33,300 or €37,500

No cover

US\$75,000 or £50,000 or €56,250

US\$100,000 or £66,600 or €75,000

Inpatient and daypatient mental health treatment (12-month waiting period)

Inpatient and **daypatient** treatment received in a recognised mental health unit of a **hospital**. **Your** cover under this benefit is subject to the lifetime mental health **treatment** limit above.

Up to 30 days per **policy year**

No cover

Cover up to the lifetime limit for mental health treatment

Cover up to the lifetime limit for mental health treatment

Outpatient 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 **doctor**. **Your** cover under this benefit is subject to the lifetime mental health **treatment** limit above.

Up to 10 consultations per **policy year** for **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital** following **inpatient** or **daypatient** mental health **treatment**

No cover

Up to 10 consultations per **policy year**

Up to 10 consultations per **policy year**

Outpatient mental health medication (12-month waiting period)

Medication prescribed by a **doctor** or registered psychiatrist to treat a mental health condition. **Your** cover under this benefit is subject to the lifetime mental health **treatment** limit above.

Up to US\$500 or £333 or €375 per **policy year** for **post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital** following **inpatient** or **daypatient** mental health **treatment**, subject to a 20% **co-insurance**

No cover

Up to US\$500 or £333 or €375 per **policy year**, subject to a 20% **co-insurance**

Up to US\$500 or £333 or €375 per **policy year**, subject to a 20% **co-insurance**

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

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 **inpatient, daypatient** 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 **policy year**

No cover

Up to US\$500 or £330 or €375 per medical condition per **policy year**

Up to US\$1,000 or £660 or €750 per medical condition per **policy year**

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

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

Outpatient treatment

Annual limit for outpatient treatment

The overall maximum limit to the amount **you** can **claim** for **treatment you** receive as an **outpatient** during any one **policy year**.

For **members** with a SilverLite plan:

- If **your employer** has selected Option A, **your** annual limit for **outpatient treatment** increases to the limit shown. **Your** limit for the primary medical care benefit (below) also increases to the limit shown for Option A.
- If **your employer** has selected Option B, **your** annual limit for **outpatient treatment** increases to the limit shown. **Your** limit for the primary medical care benefit (below) also increases to the limit shown for Option B.

You are not eligible for the higher limits if **your employer** has not selected Option A or Option B.

Full cover up to your annual plan limit

Up to US\$5,000 or £3,300 or €3,750 per **policy year**

Option A Up to US\$7,500 or £5,000 or €5,625 per **policy year**

Option B Up to US\$10,000 or £6,600 or €7,500 per **policy year**

Full cover up to your annual plan limit

Full cover up to your annual plan limit

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

Outpatient treatment (continued)

Primary medical care

Consultations with a GP, **doctor**, or **specialist**. Consultations can be in-person or via technology (e.g., video or phone call). **We** do not cover home visits.

We will also pay for the following primary medical care costs:

- Prescription drugs and other pharmacy costs (must be prescribed by a GP, **doctor**, or **specialist**)
- Pathology
- Scans
- Radiology
- **Imaging tests**

We cover COVID-19 PCR and Antigen testing when **you** have symptoms such as cough or fever or have been in close contact with someone who has tested positive for COVID-19. Tests must be prescribed by a **doctor** and undertaken under medical supervision in a recognised medical facility. **We** don't cover home testing kits.

If you have a **SilverLite** plan and **your employer** has selected Option A or Option B, **your** annual limit for primary medical care increases to the limit shown.



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 policy year** (up to the annual limit for **outpatient treatment**)



Option A Up to US\$2,500 or £1,665 or €1,875 **per policy year** (up to the annual limit for **outpatient treatment**)



Option B Up to US\$3,500 or £2,310 or €2,625 **per policy year** (up to the annual limit for **outpatient treatment**)



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 **doctor**



Up to the annual limit for **outpatient treatment**



Full cover



Full cover

Outpatient surgical procedures

Surgical procedures where it is not **medically necessary** for **you** to be admitted to **hospital** as an **inpatient** or **daypatient**.



Full cover



Up to the annual limit for **outpatient treatment**



Full cover



Full cover

Complementary treatments

Treatment by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist on the advice of a **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 policy year** 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 policy year** 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 policy year**



Up to 15 **sessions** **per policy year**

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

Outpatient treatment (continued)

Hormone replacement therapy

When prescribed by a **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 **policy year**. **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 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 or £660 or €750 per **policy year**

✔ Up to US\$250 or £165 or €188 per **policy year** up to the annual limit for **outpatient treatment**

✔ Full cover

✔ Full cover

Chronic conditions

Acute flare-ups

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

✔ **Inpatient, daypatient, and post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital**

✔ **Inpatient and daypatient treatment**, with cover for **outpatient treatment** up to the benefit limit for primary medical care

✔ 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

✔ Up to the benefit limit for primary medical care

✔ Full cover

✔ Full cover

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

Well-being benefits

Important notes:

- You are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.

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

✘ No cover

✘ No cover

✔ Up to US\$400 or £260 or €300 per **policy year**✔ Up to US\$1,200 or £780 or €900 per **policy year**

Preventive health checks and tests for adults, as follows:

- Blood tests (cholesterol, liver function, kidney function, high blood pressure, anaemia, diabetes testing/screening)
- Lung function test
- Cardiac risk testing
- Bone densitometry testing (every five years for women aged 50+)
- Neurological examination (physical examination)
- Hearing test
- Allergy patch testing (lifetime limit of one test per member)
- Smoking cessation aids prescribed by a doctor (up to US\$100 or £67 or €75 per **policy year**)
- Eye examination (limited to one test per **policy year**)

✔ Up to US\$750 or £500 or €563 per **policy year** (only if selected by **your employer**)

✔ Up to US\$2,000 or £1,330 or €1,500 per **policy year** (only if selected by **your employer**)

Cancer screening for adults, as follows:

- Annual Papanicolaou test (PAP/smear test)
- Mammogram (one every two years for members aged 45+)
- Annual prostate cancer test (only for members aged 45+)
- Colonoscopy (one every five years for members aged 50+)

The benefit limit on the Silver or Gold **plan** is extended if the enhanced well-being option is selected by **your employer**.

Vaccinations for adults

✘ No cover

✘ No cover

✔ Up to US\$300 or £200 or €225 per **policy year**✔ Up to US\$500 or £330 or €375 per **policy year**

Vaccinations for adults as follows:

- Immunisation and booster injections required under regulation of the country in which **treatment** is being given
- Medically necessary** travel vaccinations
- Malaria prophylaxis
- Flu jabs
- Approved COVID-19 vaccinations (where not available free of charge in **your country of residence**)

Well-child benefit (6-month waiting period)

✘ No cover

✘ No cover

✔ Up to US\$400 or £260 or €300 per **policy year**✔ Up to US\$800 or £520 or €600 per **policy year**

Immunisations and booster injections that form part of government-recommended programmes within the child's **country of residence**, allergy patch testing, and routine developmental check-ups (including vision and hearing).

We will waive the **waiting period** if either parent has been insured on the **policy** for at least 6 months and children are covered as **eligible dependants** on the **policy**.

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

Rehabilitation treatment

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

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

Rehabilitation treatment in the form of a therapy or a combination of therapies (e.g., physical therapy, occupational therapy, speech therapy) after an acute event like a stroke.

This benefit is payable only on the written recommendation of **your treating specialist** and when **treatment** begins within 30 days of **your** discharge from **hospital**.

Up to US\$2,000 or £1,330 or €1,500 per policy year

Up to US\$2,000 or £1,330 or €1,500 per policy year

Up to US\$4,000 or £2,660 or €3,000 per policy year

Up to US\$6,000 or £4,000 or €4,500 per policy year

Home nursing costs

Important notes:

- You** must obtain pre-authorization 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 US\$5,000 or £3,330 or €3,750 per medical condition per policy year

Up to US\$8,000 or £5,300 or €6,000 per medical condition per policy year

Up to US\$10,000 or £6,660 or €7,500 per medical condition per policy year

Up to US\$15,000 or £10,000 or €11,250 per medical condition per policy year

Lifetime care

Important notes:

- You** must obtain pre-authorization 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

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

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

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

Optical care

Important notes:

- You are eligible for the benefits in this section only if they have been selected by **your employer** 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.

⊗ No cover

⊗ No cover

⊕ Up to US\$200 or £133 or €150 (only if selected by **your employer**)

⊕ Up to US\$200 or £133 or €150 (only if selected by **your employer**)

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**.

Dental costs

Important notes:

- You are eligible for the benefits in this section only if they have been selected by **your employer** 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 or periodontic consultations or **treatment** of any kind.

Emergency restorative treatment you receive as an inpatient

✔ Full cover

⚡ Up to US\$5,000 or £3,330 or €3,750 per **policy year**

✔ Full cover

✔ Full cover

Inpatient 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**.

Emergency restorative treatment you receive as an outpatient

⊗ No cover

⊗ No cover

⚡ Up to US\$500 or £330 or €375 per **policy year**

⚡ Up to US\$1,000 or £660 or €750 per **policy year**

Outpatient 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**.

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

Dental costs (continued)

Important notes:

- You are eligible for the benefits in this section only if they have been selected by **your employer** 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 or periodontic consultations or **treatment** of any kind.

Dental Basic (6-month waiting period)

⊗ No cover

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 benefit is optional on the SilverLite and Silver plans. You are not eligible for cover if **your employer** does not select a Dental Basic option. It's included as standard on the Gold plan.

⊕ Up to US\$500 or £330 or €375 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)

⊕ **Option A** Up to US\$1,000 or £660 or €750 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)

⊕ Up to US\$1,500 or £1,000 or €1,125 per **policy year**

⊕ **Option B** Up to US\$1,500 or £1,000 or €1,125 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)

Dental Plus (10-month waiting period)

⊗ No cover

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. You are not eligible for cover if neither option is selected by **your employer**.

⊗ No cover

⊕ Up to US\$1,500 or £1,000 or €1,125 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)

⊕ Up to US\$2,000 or £1,330 or €1,500 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**)

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

Maternity costs

Important notes:

- You are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.
- Dependant children included on **your policy** are not eligible for these benefits.
- You must obtain pre-authorization for all benefits in this section.
- **Treatment** of any newborn born following assisted reproduction (e.g., IVF) and within 36 weeks of conception is limited to the complications of childbirth benefit.
- Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and routine care of newborns 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 (unless there is a threat to the mother's health and **treatment** is provided in a recognised medical facility).
- We do not cover breast pumps.

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

⊗ No cover

We will pay for the following routine maternity costs:

- pre-natal tests and examinations
- post-natal **treatments** and examinations
- natural childbirth
- childbirth by caesarean section (whether planned, medically necessary, or emergency)
- any **hospital** accommodation costs for the newborn
- 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 **doctor**

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

This benefit is optional on the SilverLite and Silver plans. You are not eligible for cover if an option is not selected by **your employer**.

⊕ Up to US\$5,000 or £3,330 or €3,750 per pregnancy, subject to a 20% **co-insurance**

⊕ **Option A** Up to US\$5,000 or £3,330 or €3,750 per pregnancy, subject to a 20% **co-insurance**

⊕ Up to US\$18,500 or £12,200 or €13,875 per pregnancy

⊕ **Option B** Up to US\$7,500 or £5,000 or €5,625 per pregnancy, subject to a 20% **co-insurance**

⊕ **Option C** Up to US\$10,000 or £6,660 or €7,500 per pregnancy, subject to a 20% **co-insurance**

⊕ **Option D** Up to US\$15,000 or £10,000 or €11,250 per pregnancy, subject to a 20% **co-insurance**

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

Maternity costs (continued)

Important notes:

- You are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.
- Dependant children included on **your policy** are not eligible for these benefits.
- You must obtain pre-authorisation for all benefits in this section.
- **Treatment** of any newborn born following assisted reproduction (e.g., IVF) and within 36 weeks of conception is limited to the complications of childbirth benefit.
- Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and routine care of newborns 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 (unless there is a threat to the mother's health and **treatment** is provided in a recognised medical facility).
- We do not cover breast pumps.

Complications of childbirth (12-month waiting period)

No cover

No cover

 Up to US\$20,000 or £13,330 or €15,000 per pregnancy (only if selected by **your employer**)

Full cover

We will pay for complications experienced in childbirth, including post-partum haemorrhage, retained placental membrane, and childbirth by **emergency caesarean section**.

We will also pay under this benefit for the **treatment** of any newborn born following assisted reproduction (e.g., IVF) if the birth occurs within 36 weeks of conception. If **you** have the Gold **plan**, this is subject to a maximum limit of US\$30,000 or £20,000, or €22,500.

If **you** have a Silver or Gold **plan**, and **your** childbirth necessitates an emergency surgical procedure, and **you** have already exhausted the benefit for routine maternity care and routine care of newborns, **you** may use this benefit as additional cover for surgeons; anaesthetists; and theatre fees for complex deliveries and additional accommodation charges incurred following a surgical procedure.

Cover on the Silver **plan** is only available if the complex maternity option is selected by **your employer**.

Complications of pregnancy affecting the mother (12-month waiting period)

 Up to US\$4,800 or £3,200 or €3,600 per **policy year** Up to US\$10,000 or £6,600 or €7,500 per **policy year** Up to US\$15,000 or £10,000 or €11,250 per **policy year**

Full cover

Inpatient or **daypatient treatment** necessary as a direct result of a complication experienced during pregnancy.

We will pay only for the following complications (which arise only during pregnancy): ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth, and hydatidiform mole (also known as molar 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've** been covered by **your policy**.

You only have full cover on the Silver **plan** if **your employer** has selected the complex maternity option.

 Full cover (only if selected by **your employer**)

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

SilverLite

Silver

Gold

Maternity costs (continued)

Important notes:

- You are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.
- Dependant children included on **your policy** are not eligible for these benefits.
- You must obtain pre-authorisation for all benefits in this section.
- **Treatment** of any newborn born following assisted reproduction (e.g., IVF) and within 36 weeks of conception is limited to the complications of childbirth benefit.
- Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and routine care of newborns 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 (unless there is a threat to the mother's health and **treatment** is provided in a recognised medical facility).
- 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 policy** within 30-days of birth and any additional **premium** paid
- **Your** newborn 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.

The benefit limit on the Silver **plan** is extended if the complex maternity option is selected by **your employer**.

✕ No cover

✕ No cover

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

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

⊕ Inpatient or daypatient **treatment** received within the 90-day period following birth, up to US\$50,000 or £33,300 or €37,500 per pregnancy (only if selected by **your employer**)

Expat benefits

Important notes:

- You are eligible for the benefits in this section only if they have been selected by **your employer** 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 the Charles Taylor Group) at +44 (0) 1243 621 155 or william.russell@cegagroup.com.

✔ 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 the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.
- You must obtain pre-authorisation for all benefits in this section.

Medevac Basic

Full cover

Full cover

Full cover

Full cover

If **you** have a life-threatening or limb-threatening condition covered by **your plan** which requires immediate **inpatient 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 coverage zone** 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.

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\$75 or £50 or €56 per night

Up to US\$100 or £67 or €75 per night

Up to US\$150 or £100 or €113 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 **policy year**).

Compassionate home visit (12-month waiting period)

Lifetime limit of one claim per member

No cover

Lifetime limit of one claim per member

Lifetime limit of one claim per member

If a **close family member** dies during **your policy year** 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.

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 the benefits in this section only if they have been selected by **your employer** and they are stated on **your certificate of insurance**.
- You must obtain pre-authorisation for all benefits in this section.

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 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

Medevac Plus

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

Evacuation if **you** need **advanced imaging** 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 coverage zone**, 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 coverage zone** 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 coverage zone**, 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 **policy year**) 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).

Cover is only available if the Medevac Plus option is selected by **your employer**.

Full cover (only if selected by **your employer**)

Full cover (only if selected by **your employer**)

Full cover (only if selected by **your employer**)

Full cover (only if selected by **your employer**)

Accidental death benefit

Accidental death benefit

The accidental death benefit becomes payable if a **member** dies as a consequence of an accidental bodily injury that is suffered during the **policy year**, provided that:

- The **plan** was in full force at the time the accidental bodily injury is sustained
- Death occurs within one year of the date on which accidental bodily injury is sustained
- The accidental bodily injury is not caused directly or indirectly by any risk excluded in this **agreement** or by any **special terms** stated on **your certificate of insurance**.

No cover

No cover

No cover

US\$15,000 or £10,000 or €11,250

What you're not covered for

The following are not covered by **your plan**, as well as any specific exclusions stated on **your certificate of insurance**, and other exclusions stated within the **table of benefits**. Other benefits, as stated within the **table of benefits**, may also be restricted or excluded depending on **your plan**.

All conditions, tests, **treatments** or increased **treatment** costs **you** incur because of complications that occur directly or indirectly as a consequence of **treatment** of any excluded condition will also not be covered.

We will also not pay for the fees and charges listed below and **you** will be responsible for them:

- fees for the completion or providing of **claim** forms or any other medical reports or forms such as **medical referral letters**, even if **we** have requested them;
- bank charges incurred as a result of **us** transferring money;
- losses **you** may incur due to fluctuations in exchange rates;
- charges incurred as the result of payment errors that arise as the result of **you** having provided **us** with incorrect information;
- administration, registration, or cancellation fees charged by **hospitals, doctors**, or other providers of medical services; and
- any charges made by **your** bank or credit card company.

Accidents or injuries resulting from your failure to adhere to local motoring laws

You are not covered for accidents or injuries arising from:

- travelling in, or on, a motorised vehicle as a driver or passenger, if the driver does not have a valid license and insurance, as required by the law of the country where the accident or injury occurred; and
- failure to wear the relevant safety equipment, (including, but not limited to helmets and seatbelts) as required by the law of the country where the accident or injury occurred.

Accidental death

You are not covered for the accidental death benefit when **your** death results from:

- war, warlike activities, military action, acts of foreign hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection, usurped power, mutiny, riot, strike, martial law, state of siege, attempted overthrow of government, any acts of terrorism, murder, attempted murder, kidnap (including attempted kidnap or attempted rescue from kidnapping), or assault of any kind, anywhere in the world (irrespective of whether the **member** is an active participant in any of the above activities or merely an innocent bystander);
- any illness or disease;
- food poisoning or bacterial infections (except infection which occurs through accidental cut or wound);
- suicide, or the consequences of attempted suicide;
- intentionally self-inflicted injuries, whether sane or insane;
- intentional inhalation of gas, or intentional ingestion of poisons

or drugs;

- intentionally contracted infection by bacteria or virus;
- being under the influence of alcohol or drugs; or
- an accident whilst participating in a hazardous activity.

Addictive conditions or disorders, and alcohol, drug, and solvent abuse

You are not covered for **treatment** related to:

- addictions (such as alcohol or drug addiction) or substance abuse (such as alcohol, drug or solvent abuse);
- any illness or injury caused directly or indirectly as a result of any such abuse or addiction; or
- any illness or injury caused directly or indirectly as a result of being under the influence of any substance (such as alcohol, drugs or solvents).

Allergy testing and/or desensitisation

You are not covered for **treatment** related to:

- allergy testing by hair analysis; or
- allergy desensitisation or food neutralising injections.

Alternative treatment and therapies

You are not covered for alternative **treatments** and therapies, including, but not limited to, aqua physiotherapy, bone-setting, colonic irrigation, hydrotherapy, Intervertebral Differential Dynamics (IDD), kinesiology, naturotherapy, Ayurveda and massage therapy.

Artificial life maintenance

You are not covered for **artificial life maintenance**, other than any benefit **you** are eligible for in the *lifetime care* section of the **table of benefits**.

Birth control, sexual problems and gender reassignment

You are not covered for **treatment** directly or indirectly arising from or connected with:

- contraception or sterilisation;
- sexual problems (including impotence and decreased libido); or
- gender reassignment

Chemical exposure and contamination

You are not covered for investigations or **treatment** related to any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.

Circumcision

You are not covered for **treatment** related to circumcision, unless it is required for **treatment** of an **acute medical condition** covered by **your plan**.

Commercially available substances

You are not covered for commercially available substances that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic substances, moisturisers, oils, creams, or other pharmaceutical products, other than any **treatment** available to **you** under the routine maternity care and childbirth benefit in the *maternity costs* section of the **table of benefits**.

Convalescence, rehabilitation, nursing homes, and health spas or hydros

You are not covered for:

- **hospital** accommodation if the reason **you** are hospitalised is for the purpose of convalescence, **rehabilitation** or supervision;
- relaxation or rest **treatments**, or **treatments** in nature cure clinics, health spas and health hydros; or
- private beds registered as nursing homes attached to such establishments or a **hospital** where the **hospital** has effectively become **your** home or permanent abode.

Other than **treatment** **you** are eligible for under the rehabilitation **treatment** benefit.

Cosmetic surgery/treatment and the removal of healthy tissue

You are not covered for investigations or **treatment**, even when medically prescribed, that are related to:

- cosmetic or aesthetic **treatment** to enhance **your** appearance;
- the removal of healthy tissue, including fat, skin or breast tissue;
- breast enlargement or reduction;
- sclerotherapy for spider veins, **treatment** of superficial varicose veins; or
- Botox, dermal fillers, or **treatment** of vitiligo or any skin pigmentation **disorder**.

Other than the **treatment** **you** are eligible for under the reconstructive surgery benefit.

Criminal activity

You are not covered for **treatment** arising from or related to injuries sustained while **you** are engaged in a criminal, illegal or unlawful act.

Dietitian

You are not covered for **treatment** or advice by a dietitian or nutritionist (unless covered under **your plan** under the dietitian benefit in the *cancer treatment* section of the **table of benefits**).

Experimental drugs and treatments

You are not covered for **treatment** or medicine which in **our** reasonable opinion is experimental or unproven based on generally accepted current clinical evidence and generally accepted medical practice.

Eyesight

You are not covered for:

- LASIK eye surgery or any other surgical correction of short-sightedness (myopia), long-sightedness (hyperopia) or irregular-shaped cornea (astigmatism);
- any lens other than a standard mono-focal replacement lens as part of an eye operation, such as cataract surgery;
- spectacles, and other visual aids, treatment of strabismus (squint) or amblyopia (lazy eye); or
- sight tests (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**).

Failure to follow medical advice

You are not covered for:

- **treatment** arising from or related to **your** unreasonable failure to seek or follow medical advice and/or prescribed **treatment**, or **your** unreasonable delay in seeking or following such medical advice and/or prescribed **treatment**; or
- complications arising from ignoring such advice.

Foetal surgery

You are not covered for surgery undertaken on a child while it is in its mother's womb.

Genetic testing or genetic engineering

You are not covered for genetic testing or genetic engineering, other than **treatment** **you** are eligible for under the cancer genome tests or genetic testing for cancer benefits in the *cancer treatment* section of the **table of benefits**.

Hearing

You are not covered for:

- **treatment** for or arising from deafness caused by maturing or ageing;
- **treatment** for or arising from deafness caused by a **congenital condition** if either the abnormality was diagnosed, or **you** were showing signs or symptoms of the abnormality, before **your date of entry** (unless covered under **your plan** under the **treatment for congenital conditions** or hereditary conditions for newborn babies benefit in the *maternity costs* section of the **table of benefits**);
- hearing aids; or
- hearing tests (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**).

Infertility, IVF, and assisted reproduction

You are not covered for:

- testing or diagnosis related to infertility; or
- infertility **treatment**, **assisted reproduction** (e.g., IVF **treatment**), including establishing pregnancy.

Learning and educational difficulties

You are not covered for learning and educational difficulties, including, but not limited to, dyslexia and speech disorders.

Natural changes as a result of ageing

You are not covered for:

- **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing; (e.g., menopause or puberty);
- bone densitometry (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**); or
- reproductive hormone testing, reproductive hormone therapy or hormone replacement therapy (unless covered under **your plan** under the hormone replacement therapy benefit in the *outpatient treatment* section of the **table of benefits**).

Palliative care

You are not covered for **palliative care** other than cover available to you for the **palliative care** of a **terminal medical condition** in the *lifetime care* section of the **table of benefits**.

Persistent vegetative state and neurological damage

You are not covered for **treatment** received after:

- you have been in a **vegetative state** for a period of eight weeks; or
- you have sustained permanent neurological damage and remained in **hospital** for a period of eight weeks.

Except for any **treatment** you are eligible for under the *lifetime care* section of the **table of benefits**.

Physical development, learning difficulties, speech disorders, and behavioural problems

You are not covered for any consultations, tests required to diagnose or exclude a diagnosis, or **treatment** of or related to:

- developmental delays;
- learning and education difficulties, including, but not limited to, dyslexia and speech disorders;
- behavioural problems, including, but not limited to, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), and Tourette's syndrome;
- physical development of any kind;
- teething; or
- bed wetting.

Pre-existing medical conditions or related conditions

The terms and conditions governing **pre-existing medical conditions** or **related conditions** depend on the **medical underwriting** type of **your employer's plan**. The type of **medical underwriting** you have is stated on **your certificate of insurance**.

Full medical underwriting or CPME underwriting

You are not covered for **treatment** related to any **pre-existing medical conditions** and **related conditions** that you did not declare on **your application form**.

We rely on the information you provide us when we decide whether or not to accept **your application**, and whether or not we need to apply **special terms**. Unless we have agreed otherwise, **your policy** does not cover any **pre-existing medical condition** or **related conditions**.

Moratorium underwriting

You are not covered for **treatment** related to **pre-existing medical conditions** or **related conditions** that you knew about or for which you have experienced symptoms, sought medical advice, or received medical **treatment** in the two-year period before **your date of entry**.

A **pre-existing medical condition** may become eligible for benefit after two years of continuous cover, provided you have not experienced symptoms, consulted a **doctor**, sought medical advice, received medical **treatment** (including routine check-ups), taken medication (including injections), or been advised to follow a special diet for that **pre-existing medical condition** or a **related condition** during that two-year period.

If sound medical advice dictates that you *should* have consulted a **doctor**, sought medical advice, received medical **treatment** (including routine check-ups), taken medication (including injections), or been advised to follow a special diet for a **pre-existing medical condition** or a **related condition** during that two-year period, the **pre-existing medical condition** will not become eligible for benefit. Please do not delay receiving medical **treatment** or advice in order to qualify a **pre-existing medical condition** for benefit.

If there is any doubt whether a medical condition is a **pre-existing medical condition** or not, the decision of our Chief Medical Officer is final. We reserve the right to request a further medical opinion.

MHD underwriting

You, and any **eligible dependants**, have cover for **pre-existing medical conditions** and **related conditions** provided that you joined your **employer's plan** on its original start date and provided that **your employer** completed its **application form** to the best of its knowledge and belief.

Preventive surgery

You are not covered for surgery when no physical signs or symptoms are shown, or no diagnosis has been made, other than **treatment** you're eligible for under the cancer preventive **treatment** benefit in the *cancer treatment* section of the **table of benefits**.

Professional sports and motorised racing as an amateur or a professional

You are not covered for **treatment** for an illness or injury related to:

- participation in (including training for or practising for) any kind of professional sport or professional racing (by professional, we mean sport where you are being paid to participate and/or you are receiving sponsorship or other benefits as a result of **your** participation); or
- participation in (including training for or practising for) any kind of racing (whether amateur or professional) which involves the use of a motorised vehicle.

Scalp conditions

You are not covered for:

- **treatment** specifically related to scalp conditions, including, but not limited to, alopecia; or
- wigs (unless covered under **your plan** in the *cancer treatment* section of the **table of benefits**).

Search and/or rescue

You are not covered for:

- search and/or rescue operations, including (but not limited to) mountain rescue, rescue from ski slopes or pistes, underground rescue, or underwater rescue; or
- evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht.

Self-inflicted injuries

You are not covered for **treatment** of self-inflicted injuries or **treatment** of any injury or illness directly or indirectly caused by self-inflicted injuries.

Sexually-transmitted infections

You are not covered for **treatment** related to sexually-transmitted infections including genital/anal warts.

Sleep disorders

You are not covered for **imaging tests** for or **treatment** of any sleep related disorder, including, but not limited to, insomnia, snoring and sleep apnoea.

Stem-cell harvesting

You are not covered for stem cell harvesting other than prior to a stem cell transplant, or any **treatment** undertaken in anticipation of, prior to, or following such harvesting.

Sundry medical supplies

You are not covered for non-prescribed items such as hot and cold packs and support bandages, unless these are required as a result of **treatment** received during a medical emergency.

Temporomandibular joint (TMJ) disorders

You are not covered for treatment of disorders of the Temporomandibular joint (TMJ) including any **related condition**.

Travel costs

You are not covered for travel costs including airfares and hotel accommodation (unless covered under **your plan** in the *expat benefits* section of the **table of benefits**).

Treatment by a related party

You are not covered for **treatment** provided by and/or under the control of and/or on referral from:

- any family member, including, but not limited to, a spouse, partner, parent, brother, sister, child, grand-parent, grand-child, uncle or aunt; or
- any **medical services provider, medical practitioner or specialist** where the **member** has a financial interest and/or a professional interest, including, but not limited to, employees, employers, consultants and owners.

War and terrorism

You are not covered for **treatment** arising directly or indirectly from war, foreign enemy hostility, terrorism, rebellion, civil war, revolution, military coup, riot, strike, martial law, state of siege or attempted overthrow of a government, unless **you** are an **innocent bystander**.

Weight-related conditions and eating disorders

You are not covered for investigations or **treatment** related to:

- obesity, or which is necessary because of obesity;
- weight monitoring or control, such as slimming classes, aids and drugs;
- bariatric surgery, or complications resulting from bariatric surgery; or
- eating disorders of any kind, such as anorexia nervosa or bulimia.

Wilful exposure to needless danger

You are not covered for **treatment** of any conditions arising directly or indirectly from **your** gross negligence and/or **your** wilful exposure to needless danger except in an attempt to save a human life.

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