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.

Additional cover in the USA

If **you** have the 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.

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 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 for these benefits, **we** will only pay 80% of the **reasonable and customary** cost of **treatment**.

If **your certificate of insurance** indicates that **you** have cover for **treatment** in a semi-private room or general ward, and **you** receive **treatment** in a higher tier room, then the cover **we** provide for all of **your treatment** and accommodation costs will be subject to a **co-insurance**. This means **you** will need to contribute towards **your treatment** and accommodation costs.

If **your certificate of insurance** indicates that **you** do not have full cover for **treatment** in a private room, in a **restricted hospital in Hong Kong** and **you** receive **treatment** in a private room in a **restricted hospital in Hong Kong** then the cover **we** provide for all of **your treatment** and accommodation costs will be subject to a **co-insurance**.

If **your certificate of insurance** indicates that you have cover for **treatment** in a semi-private room or in a general ward, and also that **you** do not have cover for full **treatment** in a private room in a **restricted hospital in Hong Kong**, and **you** receive treatment in a higher tier room than **you** are entitled to, in a restricted hospital in Hong Kong, both **co-insurances** will apply to your claim.

For more detail please refer to the *If you need to make a claim receiving treatment in a higher tier room or restricted hospital* section of this **agreement**.

The **table of benefits** should be read in conjunction with the *What you're not covered for* section of this **agreement**. This section explains what **we** mean by certain words and phrases bolded in this **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 **member** can **claim** during any one **policy year**.	US$1,500,000 or £1,000,000 or €1,125,000	US$2,500,000 or £1,666,000 or €1,875,000	US$5,000,000 or £3,333,000 or €3,750,000
Hospital costs Important notes: • **You** must obtain pre-authorisation for all benefits in this section.			
Hospital accommodation General Ward - The cost of accommodation on a general ward with three or more beds, when **you** are an **inpatient** or **daypatient**. Semi-private hospital room - The cost of a standard shared room with an en-suite bath or shower room, when **you** are an **inpatient** or **daypatient**. Private hospital room - The cost of a standard single room with an en-suite bath or shower room, when **you** are an **inpatient** or **daypatient**. Accommodation in a semi-private hospital room or private hospital room (with or without **restricted hospital in Hong Kong co-insurance**) is only available if **your employer** has selected this option.	✓ General ward + Semi-Private hospital room + Private hospital room - 20% **co-insurance** applies to **treatment** in a **restricted hospital in Hong Kong** + Private hospital room	✓ General ward + Semi-Private hospital room + Private hospital room - 20% **co-insurance** applies to **treatment** in a **restricted hospital in Hong Kong** + Private hospital room	✓ General ward + Semi-Private hospital room + Private hospital room - 20% **co-insurance** applies to **treatment** in a **restricted hospital in Hong Kong** + Private hospital room

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.			
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, **diagnostic 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 **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
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
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	✓ 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$350 or £231 or €263 per night
Acute flare-ups of chronic conditions 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**	✓ 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
Cancer genome tests The cost of tests to sequence the genes of cancer cells.	✓ Up to US$6,000 or £4,000 or €4,500 per **policy year**	✓ Up to US$6,000 or £4,000 or €4,500 per **policy year**	✓ Up to US$6,000 or £4,000 or €4,500 per **policy year**

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.			
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– 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 or £3,330 or €3,750 with a lifetime limit of one claim per **member**
Wigs Help towards the cost of a wig following chemotherapy, covered by **your plan**.	◐ 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
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$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$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
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

Key ✓ Full cover within annual benefit limit ✎ Partial or limited cover ✕ No cover ⊕ Optional cover

	Bronze	Silver	Gold
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
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**	✓ 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$20,000 or £13,300 or €15,000	✎ Lifetime limit of US$40,000 or £26,600 or €30,000	✎ Lifetime limit of US$80,000 or £53,300 or €60,000

Key ✓ Full cover within annual benefit limit | ⚠ Partial or limited cover | ✗ No cover | ⊕ Optional cover

	Bronze	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	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**.	⚠ Up to 30 days per **policy year**	⚠ Up to 30 days per **policy year**	⚠ Up to 30 days per **policy year**
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**. **We** do not pay for drugs prescribed for **outpatient** mental health **treatment**. **Your** cover under this benefit is subject to the lifetime mental health **treatment** limit.	⚠ 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**	⚠ Up to 10 consultations per **policy year**	⚠ Up to 10 consultations per **policy year**
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$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**
Medical appliances			
Medical aids Supplying, fitting or hiring instruments, apparatuses or devices which are medically prescribed as a medical aid to **you** (for example 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**	⚠ 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**

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 or £330 or €375 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 Important notes: • **You** must obtain pre-authorisation for certain benefits in this section. • Certain benefits in this section are subject to the annual limit for **outpatient treatment**.			
Annual limit for outpatient treatment The overall maximum limit to the amount **you** can **claim** for certain **treatments you** receive as an **outpatient** during any one **policy year**.	Full cover up to your annual plan limit	US$20,000 or £13,300 or €15,000	US$30,000 or £20,000 or €22,500
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.	⚠ **Post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital** (subject to a 15% **co-insurance**) ⊕ **Post-hospital treatment** received within the 90-day period following the date **you** are discharged from **hospital** (only if selected by **your employer**)	⚠ 25 consultations, subject to the annual limit for **outpatient treatment** and a 15% **co-insurance** ⊕ 25 consultations, subject to the annual limit for **outpatient treatment** (only if selected by **your employer**)	⚠ 30 consultations, subject to the annual limit for **outpatient treatment**
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**	✓ Full cover	✓ Full cover

Key ✓ Full cover within annual benefit limit | ⚠ Partial or limited cover | ✗ No cover | ⊕ Optional cover

	Bronze	Silver	Gold
Outpatient treatment (continued) Important notes: • **You** must obtain pre-authorisation for certain benefits in this section. • Certain benefits in this section are subject to the annual limit for **outpatient treatment**.			
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	✓ Full cover	✓ Full cover
Advanced diagnostic 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 **diagnostic test**. **You** must obtain pre-authorisation for all advanced **diagnostic tests**.	✓ Full cover	⚠ Up to the annual limit for **outpatient treatment**	⚠ Up to the annual limit for **outpatient treatment**
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**	⚠ Up to 10 **sessions** per **policy year**, subject to the annual limit for **outpatient treatment**	⚠ Up to 15 **sessions** per **policy year**, subject to the annual limit for **outpatient treatment**
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	⚠ Up to US$50 or £33 or €38 per **session**, up to a maximum of 15 **sessions**, subject to the annual limit for **outpatient treatment**	⚠ Up to US$50 or £33 or €38 per **session**, up to a maximum of 20 **sessions**, subject to the annual limit for **outpatient treatment**
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 **period of cover**	⚠ Up to the annual limit for **outpatient treatment**	⚠ Up to the annual limit for **outpatient treatment**
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	⚠ Maximum period of 12 months from the date of diagnosis	⚠ Maximum period of 18 months from the date of diagnosis

Key ✓ Full cover within annual benefit limit | ⁄ Partial or limited cover | ✗ No cover | + Optional cover

	Bronze	Silver	Gold
Outpatient treatment (continued) Important notes: • **You** must obtain pre-authorisation for certain benefits in this section. • Certain benefits in this section are subject to the annual limit for **outpatient treatment**.			
Monitoring and maintenance of chronic conditions Regular consultations, tests, and prescribed medication required to monitor and maintain the stability of a **chronic condition**. The removal of the outpatient co-insurance on Silver plans is only available if your employer has selected this option.	✗ No cover	⁄ Up to the annual limit for **outpatient treatment** (subject to a 15% **co-insurance**) + Up to the annual limit for **outpatient treatment**	⁄ Up to the annual limit for **outpatient treatment**
Well-being benefits			
Preventive health and well-being (6-month waiting period) **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 • Hearing test • Eye examination (limited to one test per **policy year**) 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+)	✗ No cover	⁄ Up to US$300 or £200 or €225 per **policy year**	⁄ Up to US$750 or £500 or €563 per **policy year**
Vaccinations for adults 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**)	✗ No cover	⁄ Up to US$150 or £100 or €113 per **policy year**	⁄ Up to US$250 or £167 or €188 per **policy year**
Well-child benefit (12-month waiting period) Immunisations and booster injections that form part of government-recommended programmes within the child's **country of residence** and routine developmental check-ups (including vision and hearing).	✗ No cover	⁄ Up to US$200 or £133 or €150 per **policy year**	⁄ Up to US$400 or £260 or €300 per **policy year**

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 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 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 US$5,000 or £3,330 or €3,750 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-authorisation for all benefits in this section.			
Lifetime limit for all lifetime care The overall maximum limit to the amount that **you** can **claim** for all benefits in the *lifetime care* section that are covered by **your plan** during **your** lifetime.	US$25,000 or £16,600 or €18,750	US$50,000 or £33,300 or €37,500	US$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
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

Key ✓ Full cover within annual benefit limit | ⚠ Partial or limited cover | ✗ No cover | ⊕ Optional cover

	Bronze	Silver	Gold
Lifetime care (continued) Important notes: • **You** must obtain pre-authorisation for all benefits in this section.			
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
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. **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 or £133 or €150 (only if selected by **your employer**)	⊕ Up to US$200 or £133 or €150 (only if 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 **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**.	✓ Full cover	✓ Full cover	✓ Full cover
Emergency restorative treatment you receive as an outpatient **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**.	✗ 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**
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 £660 or €750, or US$1,500 or £1,000 or €1,125, 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 or £660 or €750 per **policy year**, subject to a 10% **co-insurance** (only if selected by **your employer**) ⊕ **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**)	⚠ Up to US$1,500 or £1,000 or €1,125 per **policy year**

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 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 Plus (10-month waiting period) **We** will pay for the following advanced dental costs: • denture repair • full/partial dentures • dental bridges • crowns, inlays, and onlays • dental implants This benefit is optional on the Silver and Gold **plans**. **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**)
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 in **your plan** are not eligible for these benefits. • **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 **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. The routine maternity care and childbirth benefit on the Silver **plan** is limited to US$5,000 or £3,330 or €3,750, or US$7,500 or £5,000 or €5,625, or US$10,000 or £6,660 or €7,500, depending on which option **your employer** has selected. **You** are not eligible for cover if no option is selected.	✗ No cover	⊕ **Option A** Up to US$5,000 or £3,330 or €3,750 per pregnancy, subject to a 20% **co-insurance** ⊕ **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**	✓ Up to US$15,000 or £10,000 or €11,250 per pregnancy

Key ✓ Full cover within annual benefit limit | ⁄ Partial or limited cover | ✗ No cover | + Optional cover

	Bronze	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 in **your plan** are not eligible for these benefits. • **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.			
Complications of pregnancy (12-month waiting period) **Inpatient** or **daypatient 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 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 the **plan**. The benefit limit on the Silver **plan** is extended to full cover if the complex maternity option is selected by **your employer**.	⁄ Up to US$4,800 or £3,200 or €3,600 per **policy year**	⁄ Up to US$15,000 or £10,000 or €11,250 per **policy year** + 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**. Cover on the Silver **plan** is only available if the complex maternity option is selected by **your employer**.	✗ No cover	+ Up to US$20,000 or £13,330 or €15,000 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	⁄ **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$50,000 or £33,300 or €37,500 per pregnancy (only if selected by **your employer**)	⁄ **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

Key ✓ Full cover within annual benefit limit | ~ Partial or limited cover | ✗ No cover | + Optional cover

	Bronze	Silver	Gold
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 621155 or william.russell@cegagroup.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 **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.	✓ 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 **policy year**).	~ Up to US$72 or £48 or €54 per night	~ Up to US$96 or £64 or €72 per night	~ Up to US$250 or £167 or €188 per night
Compassionate home visit (12-month waiting period) 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.	~ Lifetime limit of one claim per member	~ Lifetime limit of one claim per member	~ Lifetime limit of one claim per member
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

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 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
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 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**)

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. **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
- 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
- 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

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
- 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
- allergy desensitisation or food neutralising injections

We will only pay for patch testing if **you** have been referred by a **doctor** and this is limited to one patch testing investigation over the lifetime of **your plan**. **Your medical referral letter** will be required.

Alternative treatment and therapies

You are not covered for alternative **treatment** 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 under the lifetime care benefit.

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)
- 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**.

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
- 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 and treatment

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

- cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed
- the removal of fat or surplus tissue
- breast enlargement or reduction
- sclerotherapy for spider veins, **treatment** of superficial varicose veins
- 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**).

Drugs prescribed for outpatient mental health treatment

You are not covered for drugs prescribed for **outpatient** mental health **treatment**. However, there may be some cover under the *cancer **treatment**, counselling* 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); however, lenses, frames and contact lenses may be covered under the optional optical care benefit
- sight tests (unless covered under **your plan** in the *well-being benefits* or *optical care* sections 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
- 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 benefit 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
- hearing tests (unless covered under your plan in the *well-being benefits* section of the **table of benefits**)

Learning and educational difficulties

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

Infertility, IVF, and assisted reproduction

You are not covered for:

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

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
- 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
- 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 benefit.

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
- bed wetting

Pre-existing medical conditions or related conditions

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

- any **pre-existing medical conditions** of the following types and any **related conditions**, if **you** have ever had them at any time before **your date of entry**, unless **we** have agreed otherwise:
  - *brain or nervous system conditions*
  - *cancer, tumours or growths*
  - *heart or circulatory conditions*
  - *mental health conditions, drug and alcohol issues or sleep disorders*
  - *joint replacements*; and
- any other **pre-existing medical conditions** and **related conditions** that **you** have had during the five years before **your date of entry**, unless **we** have agreed otherwise.

Preventive surgery

You are not covered for surgery when no physical signs or symptoms are shown, or diagnosis has been made.

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)
- participation in (including training for or practising for) any kind of racing (whether amateur or professional) which involves the use of a motorised vehicle

Repeat prescriptions and longer-term medication

We will only pay for medication that has been prescribed for **you** to use during **your policy year**. If **you** are prescribed medication that **you** need to take after **your policy year** has expired, **we** will pay for the proportion of the medication **you** need to take during **your policy year**.

Scalp conditions

You are not covered for:

- **treatment** specifically related to scalp conditions, including, but not limited to, alopecia
- 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 or 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

Second opinions or duplicate tests

You are not covered for second or subsequent opinions from a **doctor**, **medical practitioner** or **specialist** or for duplicate tests for the same condition.

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 diseases

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

Sleep disorders

You are not covered for **diagnostic 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
- 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

Vitamins, dietary supplements, natural substances, and creams

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**.

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
- 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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