

BENEFITS OF THE GLOBAL HEALTH ELITE PLANS

The following **table of benefits** sets out the cover provided by the Global Health plans.

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** 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**.

The limits shown in the **table of benefits** are the maximum amounts **we** will pay after the application of any **excess** and **co-insurance**.

Where the term full cover appears, this means full refund of reasonable and customary charges, less any excess applicable to your plan, and subject to any co-insurance and/or any benefit limits and/or number of session limits shown in the table of benefits, to include any limits in other benefits elsewhere in the table applying to your claim.

KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

	BRONZE	SILVER	GOLD
<p>Annual benefit limit</p> <p>The overall maximum limit that each insured person can claim during any one period of cover.</p>	US\$1,500,000 or £950,000 or €1,100,000	US\$2,500,000 or £1,500,000 or €1,800,000	US\$4,500,000 or £2,800,000 or €3,300,000
<p>COVER WHEN YOU ARE ADMITTED TO HOSPITAL</p> <p>IMPORTANT NOTE: YOU MUST OBTAIN PRE-AUTHORISATION FOR ALL BENEFITS INCLUDED IN THIS SECTION</p>			
<p>Hospital accommodation charges</p> <p>Hospital accommodation charges limited to the cost of a standard single room with an ensuite bath or shower room, when you are an in-patient or day-patient.</p>	FULL COVER 	FULL COVER 	FULL COVER 
<p>In-patient and day-patient treatment</p> <p>Treatment you receive whilst you are an in-patient or day-patient, including surgeons', anaesthetists' and doctors' fees, nursing care, drugs and surgical dressings, theatre charges and intensive care, pathology, x-rays, scans, diagnostic tests and physiotherapy.</p>	FULL COVER 	FULL COVER 	FULL COVER 
<p>Parent accommodation charges</p> <p>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.</p>	FULL COVER 	FULL COVER 	FULL COVER 
<p>Hospital cash benefit</p> <p>Payable for each night spent in a hospital when you receive treatment eligible for cover by your plan for which no charge is made by the hospital. Benefit is paid for up to a maximum of 60 nights per period of cover.</p>	US\$40 or £25 or €30 per night 	US\$80 or £50 or €60 per night 	US\$250 or £156 or €187 per night 
<p>Road ambulance</p> <p>The cost of a private road ambulance if you need in-patient or day-patient treatment for which you are covered by your plan, and if it is medically necessary for you to travel to the hospital by local road ambulance.</p>	FULL COVER 	FULL COVER 	FULL COVER 

KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

IF YOU ARE DIAGNOSED WITH CANCER

IMPORTANT NOTE: YOU MUST OBTAIN PRE-AUTHORISATION FOR ALL BENEFITS INCLUDED IN THIS SECTION

In-patient and day-patient cancer treatment

Cancer **treatment** required as an **in-patient** or **day-patient** including chemotherapy and radiotherapy.

FULL COVER



FULL COVER



FULL COVER



Out-patient cancer treatment

Out-patient consultations, tests and scans.

FULL COVER



FULL COVER



FULL COVER



Cancer genome tests

The cost of test(s) to sequence the genes of cancer cells.

Cover up to
US\$2,000 or
£1,250 or €1,500
**per period of
cover**



Cover up to
US\$2,000 or
£1,250 or €1,500
**per period of
cover**



Cover up to
US\$2,000 or
£1,250 or €1,500
**per period of
cover**



Wigs

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

Lifetime limit of
US\$150 or £94 or
€113



Lifetime limit of
US\$150 or £94 or
€113



Lifetime limit of
US\$150 or £94 or
€113



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. **We** do not cover any drugs prescribed under this benefit.

Lifetime limit of
US\$500 or £313 or
€376



Lifetime limit of
US\$500 or £313 or
€376



Lifetime limit of
US\$500 or £313 or
€376



Dietician

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

Lifetime limit of
US\$100 or £63 or
€76



Lifetime limit of
US\$100 or £63 or
€76



Lifetime limit of
US\$100 or £63 or
€76



IF YOU NEED RECONSTRUCTIVE SURGERY

IMPORTANT NOTE: YOU MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

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

Cover for
**in-patient,
day-patient and
post-hospital
treatment**



FULL COVER



FULL COVER



KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

IF YOU NEED A TRANSPLANT FOR AN ORGAN, BONE MARROW OR TISSUE

IMPORTANT NOTES: YOU MUST OBTAIN PRE-AUTHORISATION FOR ALL BENEFITS INCLUDED 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 whilst hospitalised, and all related **out-patient treatment** required prior to and after the transplant.

FULL COVER



FULL COVER



FULL COVER



Donor costs

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

Cover up to
US\$25,000 or
£15,625 or
€18,750 **per
transplant**



Cover up to
US\$25,000 or
£15,625 or
€18,750 **per
transplant**



Cover up to
US\$25,000 or
£15,625 or
€18,750 **per
transplant**



IF YOU NEED KIDNEY DIALYSIS

IMPORTANT NOTE: YOU MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

Short-term kidney dialysis of up to 4 weeks, if **you** need this immediately before or after a kidney transplant operation covered by **your plan**.

FULL COVER



FULL COVER



FULL COVER



We will also pay for dialysis for up to 4 weeks if this is needed temporarily for sudden kidney failure resulting from a disease or injury, covered by **your plan**, which affects another part of **your** body.

We do not cover regular or long-term kidney dialysis.

IF YOU NEED PSYCHIATRIC CARE

IMPORTANT NOTES: YOU MUST OBTAIN PRE-AUTHORISATION FOR ALL BENEFITS INCLUDED IN THIS SECTION

- All **treatment** must be administered under the direct control of a registered psychiatrist.
- We do not cover investigations or **treatment** related to eating disorders of any kind, psycho-geriatric conditions including Alzheimer's disease or dementia, phobias, hypnotherapy, postnatal depression or marriage counselling.

Lifetime limit for all psychiatric treatment

The overall lifetime maximum limit that each **insured person** can claim for all psychiatric **treatment**.

US\$50,000 or
£31,250 or
€37,500

US\$75,000 or
£46,875 or
€56,250

US\$100,000 or
£62,500 or
€75,000

In-patient and day-patient psychiatric treatment (24-month waiting period)

In-patient and **day-patient treatment** in a recognised psychiatric unit of a **hospital**. Cover is limited to 30 days per **period of cover**.

FULL COVER



FULL COVER



FULL COVER



Out-patient psychiatric treatment (24-month waiting period)

Specialist psychiatric consultations with a registered psychiatrist when **you** have been referred by a **medical doctor**. Cover is limited to 10 consultations per **period of cover**.

Cover for
**post-hospital
treatment**



FULL COVER



FULL COVER



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

KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

COVER FOR EVERYDAY MEDICAL CARE

Emergency ward treatment

Emergency treatment that you have received at a hospital.

Cover for treatment necessary as a result of an accident



FULL COVER



FULL COVER



Out-patient surgical procedures

FULL COVER



FULL COVER



FULL COVER



Other medical care

GP and specialist consultations, prescribed drugs and dressings, pathology, scans, radiology and diagnostic tests received as an out-patient.

Cover for post-hospital treatment



FULL COVER



FULL COVER



Advanced diagnostic tests

MRI and CAT (CT) scans performed on the advice of a medical doctor. 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.

FULL COVER



FULL COVER



FULL COVER



Treatment by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist

Cover is limited to the maximum number of sessions shown, per period of cover in respect of all treatment types.

Any treatment by a chiropractor, osteopath, chiropodist or podiatrist must be on the advice of a medical doctor. Your medical referral letter will be required. If your condition becomes a chronic condition and ongoing treatment is aimed at maintaining it rather than curing it, no further payments will be made.

Cover for post-hospital treatment



(maximum 10 sessions)

FULL COVER



(maximum 10 sessions)

FULL COVER



(maximum 15 sessions)

Hormone replacement therapy prescribed by a medical doctor

When you have been diagnosed with premature ovarian failure, i.e. loss of ovarian function before the age of 40.

NOT COVERED



Cover for a maximum period of 12 months from the date of diagnosis



Cover for a maximum period of 18 months from the date of diagnosis



Traditional Chinese medicine

Cover is limited to the maximum number of sessions shown, per period of cover.

NOT COVERED



Cover up to US\$50 or £32 or €38 per session



(maximum 10 sessions)

Cover up to US\$50 or £32 or €38 per session



(maximum 15 sessions)

KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

CONTINUED: COVER FOR EVERYDAY MEDICAL CARE

Physiotherapy

Physiotherapy performed on the advice of a **medical doctor**. Your **medical referral letter** will be required. After the 10th **session**, if **you** need more **sessions**, **you** must contact **us** for pre-authorisation and **we** will require a further **medical referral letter**.

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

Cover for **post-hospital treatment** only, up to US\$1,000 or £625 or €750 **per period of cover**



FULL COVER



FULL COVER



WELL-BEING BENEFITS

Preventive health checks (6-month waiting period)

Insured persons who are adults may use this benefit to pay towards **preventive health checks**, an annual sight test, immunisations, booster injections and travel vaccinations.

NOT COVERED



Cover up to US\$300 or £188 or €226 **per period of cover**



Cover up to US\$550 or £344 or €413 **per period of cover**



Well-child benefit (12-month waiting period)

Insured persons who are children may use this benefit to pay towards routine vaccinations and developmental check-ups. There is no **waiting period** for children added to the Silver or Gold **plan** within their first 30 days of life, provided one parent has been insured with **us** for at least 12 months on the same, or an enhanced, **plan type**.

NOT COVERED



Cover up to US\$150 or £94 or €113 **per period of cover**



Cover up to US\$250 or £156 or €187 **per period of cover**



IF YOU NEED TREATMENT FOR HIV AND/OR AIDS

IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

(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, provided the HIV virus was contracted after **your date of entry**.

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

Cover for **in-patient and day-patient treatment** only, up to US\$5,000 or £3,125 or €3,750 **per period of cover**



Cover up to US\$75,000 or £46,875 or €56,250 **per period of cover**



Cover up to US\$100,000 or £62,500 or €75,000 **per period of cover**



IF YOU NEED REHABILITATION TREATMENT

IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

In-patient rehabilitation carried out under the control and supervision of a **specialist** in a recognised **rehabilitation hospital** or **unit** only when it immediately follows **in-patient treatment** covered by **your plan**.

Benefit is payable only when the admission takes place on the written recommendation of **your treating specialist** and the admission must take place immediately following **your discharge from hospital**.

Cover for up to **7 days per medical condition**



Cover for up to **15 days per medical condition**



Cover for up to **30 days per medical condition**



KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

IF YOU NEED HOME NURSING

IMPORTANT NOTE: YOU MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

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**. Cover is restricted to a maximum of 12 weeks per medical condition per **period of cover**.

FULL COVER



FULL COVER



FULL COVER



IF YOU NEED HOSPICE & PALLIATIVE CARE

IMPORTANT NOTE: YOU MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

The palliative care of a medical condition covered by **your plan**.

Lifetime limit of
US\$25,000 or
£15,625 or
€18,750



Lifetime limit of
US\$50,000 or
£31,250 or
€37,500



Lifetime limit of
US\$100,000 or
£62,500 or
€75,000



IF YOU NEED MEDICAL AIDS & DEVICES

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

We do not cover medical aids that form part of the care of a **chronic condition**.

We do not cover unprescribed medical aids such as gym equipment, even if **you** have been advised to use such an aid.

Cover up to
US\$250 or £156 or
€187 **per medical
condition per
period of cover**



Cover up to
US\$500 or £313 or
€376 **per medical
condition per
period of cover**



Cover up to
US\$1,000 or £625
or €750 **per
medical
condition per
period of cover**



IF YOU NEED PROSTHESES

Prosthetic implants and appliances

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.

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 at the time of a surgical operation covered by **your plan**.

Cover up to
US\$500 or £313 or
€376 **per device**



Cover up to
US\$1,000 or
£625 or €750 **per
device**



Cover up to
US\$1,500 or £938
or €1,126 **per
device**



KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

IF YOU NEED TREATMENT FOR PREGNANCY & CHILDBIRTH

IMPORTANT NOTES:

- DEPENDANT CHILDREN INCLUDED IN **YOUR PLAN** ARE NOT ELIGIBLE FOR THESE BENEFITS
- **We** do not provide cover under this section if **you** act as a surrogate or have anyone else acting as a surrogate for **you**.
- **We** do not cover the **treatment** of any newborn child born following **assisted reproduction** (e.g. IVF) in the event of any birth occurring within 36 weeks of conception.
- Any charges that would have been incurred as the result of normal childbirth (which includes **planned caesarean section** if this was scheduled to occur, or was occurring) will be paid from the Routine maternity care and childbirth benefit and cannot be claimed under any other benefit, but any subsequent additional surgeons', anaesthetists' and theatre fees that occur as a result of a complication which necessitates an emergency surgical procedure will be covered under the Childbirth necessitating an emergency surgical procedure benefit.
- **We** do not cover pregnancy testing.
- **We** do not cover antenatal classes or 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.

Complications of pregnancy (10-month waiting period)

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

We do not provide cover under this benefit for childbirth (which includes **planned or emergency caesarean section**). Childbirth is however covered elsewhere within this section.

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

Cover up to
US\$4,800 or
£3,000 or €3,600
**per period of
cover**



Cover up to
US\$15,000 or
£9,375 or €11,250
**per period of
cover**



FULL COVER



Childbirth necessitating an emergency surgical procedure (10-month waiting period)

Surgeons', anaesthetists' and theatre fees for childbirth which necessitates an emergency surgical procedure and any additional accommodation charges incurred as the result of the surgical procedure.

NOT COVERED



NOT COVERED



FULL COVER



Routine maternity care and childbirth (10-month waiting period)

Routine pre-natal tests and examinations, and post-natal **treatments** and examinations, and natural childbirth or childbirth by **planned caesarean section**.

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

NOT COVERED



NOT COVERED



Cover up to
US\$15,000 or
£9,375 or €11,250
per pregnancy



Cover for newborn babies

This benefit only applies to children born to **you** after **you** have been insured by the Silver or Gold **plan** for a continuous period of 10 months.

During **your** child's first 90 days of life **we** will pay for **in-patient** and **day-patient** **treatment** including the **treatment** of birth defects and **congenital conditions**. If **your** newborn child is hospitalised, **we** will pay for the cost of one parent to stay with them in **hospital**.

We will also pay for a physical examination, Vitamin K, hepatitis B vaccine, BCG vaccine, one hearing test and blood tests for PKU, congenital hypothyroidism and G6PD.

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

NOT COVERED



Cover up to
US\$10,000 or
£6,250 or €7,500
per pregnancy



Cover up to
US\$100,000 or
£62,500 or
€75,000 **per
pregnancy**



KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT










 PARTIAL OR LIMITED COVER

 NOT COVERED

IF YOU NEED COVER FOR DENTAL CARE

IMPORTANT NOTES:

- All **dental treatment** (emergency or otherwise) must be carried out by a **dentist** in a **hospital** emergency room or dental surgery.
- **We** do not cover **treatment** that is required as a result of biting on food.
- **We** do not cover damage sustained to crowns, dentures, bridge work or false teeth, other than where applicable under the Complex dental treatment benefit.

<p><u>In-patient emergency restorative dental treatment</u></p> <p>Required to restore sound, natural teeth following an accident covered by your plan, if received within 15 days of the accident.</p>	<p>FULL COVER</p> 	<p>FULL COVER</p> 	<p>FULL COVER</p> 
<p><u>Out-patient emergency dental treatment</u></p> <p>Required to treat or replace sound, natural teeth lost or damaged following an accidental injury to the mouth, and received within 72 hours of the accident.</p>	<p>NOT COVERED</p> 	<p>Cover up to US\$500 or £313 or €376 per period of cover</p> 	<p>Cover up to US\$1,000 or £625 or €750 per period of cover</p> 
<p><u>Routine dental treatment (6-month waiting period)</u></p> <p>Screening (twice per year), i.e. the assessment of diseased, missing and filled teeth, including X-rays where necessary, preventive scaling, polishing, and sealing (twice per year), fillings (standard amalgam or composite fillings only), extractions, and root-canal treatment.</p> <p>We do not provide cover under this benefit for the fitting of a crown following root-canal treatment. This is however covered within the <u>Complex dental treatment</u> benefit.</p>	<p>NOT COVERED</p> 	<p>Only covered if you have selected the Optional Dental benefit. Please see page 16 for full details</p>	<p>Cover up to US\$1,500 or £938 or €1,126 per period of cover</p> 
<p><u>Complex dental treatment (12-month waiting period)</u></p> <p>Crowns, inlays and bridges.</p>	<p>NOT COVERED</p> 	<p>Only covered if you have selected the Optional Dental benefit. Please see page 16 for full details</p>	<p>Only covered if you have selected the Optional Dental benefit. Please see page 16 for full details</p>

IF YOU NEED EMERGENCY EVACUATION

IMPORTANT NOTES: ALL COSTS MUST BE PRE-AUTHORISED AND ARRANGED BY THE ASSISTANCE SERVICE

- In a potential emergency evacuation situation, the **Assistance Service** retains the absolute right to decide whether **your** medical condition is **life-threatening**, whether or not the **treatment** could be adequately provided locally, where **you** are evacuated to and the means and method of the evacuation.

<p><u>Emergency evacuation (standard)</u></p> <p>If you, (or any child covered by the newborn benefit within its first 90 days of life), have a life-threatening condition covered by your plan which requires immediate in-patient treatment that cannot be adequately provided locally, the Assistance Service will arrange for you to be moved by air and/or by surface transportation, to the nearest hospital within your area of cover where appropriate medical treatment is available.</p> <p>We do not cover any other costs under this benefit such as hotel accommodation charges.</p> <p>We do not cover emergency evacuation to the USA.</p>	<p>FULL COVER</p> 	<p>FULL COVER</p> 	<p>FULL COVER</p> 
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KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

CONTINUED: IF YOU NEED EMERGENCY EVACUATION

Emergency evacuation (enhanced)

- If **you**, (or any child covered by the newborn benefit within its first 90 days of life):
- need advanced imaging or cancer **treatment** such as radiotherapy or chemotherapy
 - have a limb-threatening condition covered by **your plan** which requires immediate **in-patient** or **day-patient treatment** that cannot be adequately provided locally
 - have a **life-threatening condition** covered by **your plan** which requires immediate **in-patient** or **day-patient treatment** that cannot be adequately provided locally

The **Assistance Service** will arrange for **you** to be moved by air and/or by surface transportation, to the nearest **hospital** within **your area of cover** where appropriate medical **treatment** is available, to **your home country** if it is within **your area of cover**, or to **your country of residence**.

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

We do not cover emergency evacuation or repatriation to the USA, even if this is **your home country**.

If **you** do not have anyone to accompany **you** on an evacuation, **we** will pay the economy class return airfare to have one relative or friend flown to be with **you** whilst **you** receive **your treatment**. **We** will also pay up to US\$150 per day (for up to 30 days), towards their hotel accommodation costs whilst **you** remain in the country to which **you** are evacuated.

Only covered if **you** have selected the Optional emergency evacuation benefit. Please see page 17 for full details

Only covered if **you** have selected the Optional emergency evacuation benefit. Please see page 17 for full details

Only covered if **you** have selected the Optional emergency evacuation benefit. Please see page 17 for full details

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



Travelling 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 flight, **we** will pay for their economy class airfare on a scheduled flight.

FULL COVER



FULL COVER



FULL COVER



Accommodation expenses of a companion

If **your** companion is required to stay with **you** whilst **you** receive **in-patient treatment** **we** will pay towards their hotel accommodation.

Benefit is limited to a maximum of 15 nights during **your period of cover**.

Cover up to US\$72 or £45 or €54 **per night**



Cover up to US\$96 or £60 or €72 **per night**



Cover up to US\$250 or £156 or €187 **per night**



Compassionate home travel (12-month waiting period)

If a **close family member** dies during **your period of cover** **we** will pay for **your** return economy airfare to attend the funeral. Travel must take place within 28 days of the date of death. There is a lifetime limit of one claim per **insured person**.

FULL COVER



FULL COVER



FULL COVER



KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

CONTINUED: IF YOU NEED EMERGENCY EVACUATION

Repatriation of mortal remains

If **you** die as the result of a condition that is covered by **your plan** whilst **you** are outside **your home country**, **we** will pay for **your** body or ashes to be transported to **your home country** or **country of residence**.

This benefit is not available if a claim is made for Burial or cremation at the place where **you** died.

We do not provide cover under this benefit if the cause of death is suicide.

FULL COVER



FULL COVER



FULL COVER



Burial or cremation

If **you** die as the result of a condition that is covered by **your plan** whilst **you** are outside **your home country**, **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 the cause of death is suicide.

We do not provide cover under this benefit if **you** die in **your home country**.

We do not provide cover under this benefit for the costs of a religious practitioner.

Cover up to
US\$1,600 or
£1,000 or €1,200



Cover up to
US\$1,600 or
£1,000 or €1,200



Cover up to
US\$1,600 or
£1,000 or €1,200



IF YOU NEED TREATMENT FOR A CONGENITAL ABNORMALITY

IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR THIS BENEFIT

Treatment aimed to cure a congenital abnormality (whether diagnosed as a **chronic condition** or not), palliative **treatment** and care for a congenital abnormality which is diagnosed as terminal, and **treatment** for any related medical condition, provided **you** did not have signs or symptoms of the congenital abnormality prior to **your date of entry** and the congenital abnormality was diagnosed after **your date of entry**.

This benefit covers **medical practitioners'** and **specialists'** fees, surgical procedures including prostheses surgically implanted to form permanent parts of **your** body, physiotherapy, prescribed drugs and dressings, MRI, PET and CT scans, X-rays, pathology and other **diagnostic tests** and procedures.

This benefit does not extend to psychiatric **treatment** or psychotherapy, complementary medicine, traditional Chinese medicine, acupuncture or homeopathic **treatment**.

We do not cover congenital abnormalities if either they were diagnosed or **you** were showing signs or symptoms of the abnormality before **your date of entry**, but they may be covered for newborn babies under the Cover for newborn babies benefit.

The lifetime limit shown includes any benefits already paid from the Cover for newborn babies benefit in relation to any birth defects or **congenital conditions**.

Cover for
**in-patient and
day-patient
treatment**, and
**post-hospital
treatment**, up to
a **lifetime limit** of
US\$20,000 or
£12,500 or
€15,000



Lifetime limit of
US\$40,000 or
£25,000 or
€30,000



Lifetime limit of
US\$80,000 or
£50,000 or
€60,000






KEY  FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT  PARTIAL OR LIMITED COVER  NOT COVERED

IF YOU HAVE A CHRONIC CONDITION

Acute flare-ups




Cover for an acute exacerbation of a **chronic condition**.

Cover for in-patient, day-patient and post-hospital treatment 	FULL COVER 	FULL COVER 
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Monitoring and maintenance

Regular consultations, tests and prescribed medication required to monitor and maintain the stability of a **chronic condition** that is not a **pre-existing condition**.

This benefit is limited to the above **treatments** and does not include other medical **treatments**, e.g. physiotherapy aimed at maintaining stability.

NOT COVERED 	FULL COVER 	FULL COVER 
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OPTIONAL BENEFITS

Optional dental benefit available with the Silver plan

The Optional Dental benefit is only available when **you** and all **eligible dependants** on **your plan** are insured by the Elite Silver **plan**, and provided **you** and **your eligible dependants** have all paid the appropriate Optional Dental benefit **premium**.

The Optional Dental benefit provides **you**, in addition to the standard Silver **plan** benefits within the IF YOU NEED COVER FOR DENTAL CARE section, with the Routine dental treatment and Complex dental treatment benefits. Please note the IF YOU NEED COVER FOR DENTAL CARE section important notes will apply to these benefits.

KEY

 FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT

 PARTIAL OR LIMITED COVER

 NOT COVERED

SILVER

OPTIONAL DENTAL BENEFIT

Routine dental treatment (6-month waiting period)

Screening (twice per year), i.e. the assessment of diseased, missing and filled teeth, including X-rays where necessary, preventive scaling, polishing, and sealing (twice per year), fillings (standard amalgam or composite fillings only), extractions, and root-canal **treatment**.

We do not provide cover under this benefit for the fitting of a crown following root-canal **treatment**. This is however covered within the Complex dental treatment benefit.

Cover up to US\$1,000 or £625 or €750, subject to 20% **co-insurance, per period of cover**



Complex dental treatment (12-month waiting period)

Crowns, inlays and bridges.

Cover up to US\$1,500 or £938 or €1,126, subject to 20% **co-insurance, per period of cover**



Complex dental benefit available with the Gold plan

The Complex Dental benefit is only available when **you** and all **eligible dependants** on **your plan** are insured by the Elite Gold **plan**, and provided **you** and **your eligible dependants** have all paid the appropriate Complex Dental benefit **premium**.

The Complex Dental benefit provides **you**, in addition to the standard Gold **plan** benefits within the IF YOU NEED COVER FOR DENTAL CARE section (including the Routine dental treatment benefit), with the Complex dental treatment benefit. Please note the IF YOU NEED COVER FOR DENTAL CARE section important notes will apply to this benefit.

GOLD

COMPLEX DENTAL BENEFIT

Complex dental treatment (12-month waiting period)

Crowns, inlays and bridges.

Cover up to US\$2,000 or £1,250 or €1,500, subject to 20% **co-insurance, per period of cover**





Optional emergency evacuation benefit available with all plans

The optional emergency evacuation benefit is only available provided **you** and **your eligible dependants** have all paid the appropriate optional emergency evacuation benefit **premium**.

The optional emergency evacuation benefit provides **you**, in addition to the standard benefits within the IF YOU NEED EMERGENCY EVACUATION section (including the Emergency evacuation (standard) benefit), with the Emergency evacuation (enhanced) benefit. Please note the IF YOU NEED EMERGENCY EVACUATION section important notes will apply to this benefit.

KEY  FULL COVER WITHIN ANNUAL PLAN BENEFIT LIMIT  PARTIAL OR LIMITED COVER  NOT COVERED

	BRONZE	SILVER	GOLD
OPTIONAL EMERGENCY EVACUATION BENEFIT			
<p>Emergency evacuation (enhanced)</p> <p>If you, (or any child covered by the newborn benefit within its first 90 days of life):</p> <ul style="list-style-type: none"> – need advanced imaging or cancer treatment such as radiotherapy or chemotherapy – have a limb-threatening condition covered by your plan which requires immediate in-patient or day-patient treatment that cannot be adequately provided locally – have a life-threatening condition covered by your plan which requires immediate in-patient or day-patient treatment that cannot be adequately provided locally <p>The Assistance Service will arrange for you to be moved by air and/or by surface transportation, to the nearest hospital within your area of cover where appropriate medical treatment is available, to your home country if it is within your area of cover, or to your country of residence.</p> <p>If you request repatriation to your home country or to your country of residence, it may, in some cases, not be appropriate immediately due to your medical condition. In these cases we will first evacuate you to the nearest place where appropriate treatment is available within your area of cover. Once you have been stabilised, we will then repatriate you to your home country if it is within your area of cover, or your country of residence.</p> <p>We do not cover emergency evacuation or repatriation to the USA, even if this is your home country.</p> <p>If you do not have anyone to accompany you on an evacuation, we will pay the economy class return airfare to have one relative or friend flown to be with you whilst you receive your treatment. We will also pay up to US\$150 per day (for up to 30 days), towards their hotel accommodation costs whilst you remain in the country to which you are evacuated.</p>	<p>FULL COVER</p> 	<p>FULL COVER</p> 	<p>FULL COVER</p> 