William Russell
A greater degree of expat protection

BENEFITS OF THE GLOBAL HEALTH ESSENTIAL 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

	ESSENTIAL CARE	ESSENTIAL CARE PLUS
Annual benefit limit The overall maximum limit that each **insured person** can claim during any one **period of cover**.	**US$250,000**	**US$500,000**
COVER WHEN YOU ARE ADMITTED TO HOSPITAL IMPORTANT NOTE: **YOU** MUST OBTAIN PRE-AUTHORISATION FOR ALL BENEFITS INCLUDED IN THIS SECTION		
Hospital accommodation charges **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**.	**FULL COVER**	**FULL COVER**
In-patient and day-patient treatment **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.	**FULL COVER**	**FULL COVER**
Parent accommodation charges 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**
Road ambulance 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.	Cover up to US$1,200 **per period of cover**	Cover up to US$1,600 **per period of cover**
In-patient emergency restorative dental treatment Required to restore sound, natural teeth following an **accident** covered by **your plan**, if received within 15 days of the **accident**. All **treatment** under this benefit must be carried out by a **dentist** in a hospital emergency room or dental surgery.	Cover up to US$5,000 **per period of cover**	Cover up to US$10,000 **per period of cover**

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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**
Out-patient cancer treatment **Out-patient** consultations, tests, and scans.	Cover for a maximum period of five years from the later date of the surgery, or the completion of chemotherapy or radiotherapy	**FULL COVER**
Cancer genome tests The cost of test(s) to sequence the genes of cancer cells.	Cover up to US$2,000 **per period of cover**	Cover up to US$2,000 **per period of cover**

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**

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**
Donor costs Medical costs associated with the donor as an **in-patient** or **day-patient**.	Cover up to US$25,000 **per transplant**	Cover up to US$25,000 **per transplant**

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

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**. **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.	**FULL COVER**	**FULL COVER**
COVER FOR EVERYDAY MEDICAL CARE		
Annual out-patient treatment benefit limit The overall maximum limit to the amount that each **insured person** can claim for all **out-patient treatment** during any one **period of cover**.	US$2,500	US$10,000
Emergency ward treatment **Emergency treatment** that **you** have received at a **hospital**.	**NOT COVERED**	**FULL COVER**
Out-patient surgical procedures	**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**
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**. Y**our medical referral letter** will be required. **We** will pay for one consultation only to obtain the results of the **diagnostic test**.	Cover for **post-hospital treatment**	**FULL COVER**
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 up to US$250 for **post-hospital treatment per period of cover**	Cover up to US$1,000 **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**.	US$1,000 **per period of cover**	US$2,500 **per period of cover**

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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	**Lifetime limit** of US$50,000

IF YOU NEED 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**

IF YOU NEED TREATMENT FOR COMPLICATIONS OF PREGNANCY
IMPORTANT NOTE: DEPENDENT CHILDREN INCLUDED IN **YOUR PLAN** ARE NOT ELIGIBLE FOR THIS BENEFIT

(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**). **We** do not provide cover under this benefit if **you** act as a surrogate or have anyone else acting as a surrogate for **you**. **We** do not provide cover under this benefit for 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**. **We** do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy.	**NOT COVERED**	Cover up to US$5,000 **per period of cover**

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.

Emergency evacuation (standard) 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. **We** do not cover any other costs under this benefit such as hotel accommodation charges. **We** do not cover emergency evacuation to the USA.	**FULL COVER**	**FULL COVER**

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, or • have a limb-threatening condition covered by **your plan** which requires immediate **in-patient** or **day-patient treatment** that cannot be adequately provided locally, or • 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 $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 11 for full details.	Only covered if **you** have selected the Optional emergency evacuation benefit. Please see page 11 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**
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**
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.	Cover up to US$5,000	Cover up to US$10,000
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 for up to US$1,600	Cover for up to US$1,600

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

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**.	Cover for **in-patient** and **day-patient treatment**, and for **post-hospital treatment** within the Annual out-patient treatment benefit limit, up to a **lifetime limit** of US$20,000	Cover for **in-patient** and **day-patient treatment**, and for **post-hospital treatment** within the Annual out-patient treatment benefit limit, up to a **lifetime limit** of US$40,000
IF YOU HAVE A CHRONIC CONDITION		
Acute flare ups Cover for an acute exacerbation of a **chronic condition**.	Cover for **in-patient** and **day-patient treatment**, and for **post-hospital treatment** within the Annual out-patient treatment benefit limit	Cover for **in-patient** and **day-patient treatment**, and for **post-hospital treatment** within the Annual out-patient treatment benefit limit
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**	Cover subject to an overall maximum limit (regardless of the number of chronic conditions) of US$1,000 **per period of cover** within the Annual out-patient treatment benefit limit

OPTIONAL BENEFITS

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

	ESSENTIAL CARE	ESSENTIAL CARE PLUS
OPTIONAL EMERGENCY EVACUATION BENEFIT		
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, or • have a limb-threatening condition covered by **your plan** which requires immediate **in-patient** or **day-patient treatment** that cannot be adequately provided locally, or • 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 $150 per day (for up to 30 days), towards their hotel accommodation costs whilst **you** remain in the country to which you are evacuated.	FULL COVER	FULL COVER