

SUMMARY TABLE OF BENEFITS

This table is a summary only - for full details of your cover please refer to the plan agreement.

Important Notes:

- Full cover means full refund of reasonable and customary charges, less any excess applicable to the plan, and subject to any coinsurance and/or any benefit limits and/or number of session limits shown in the table of benefits in the relevant plan agreement, to include any limits in other benefits elsewhere in the table applying to the claim.
- Partial or Limited cover means cover is offered, but is subject to the limits stated in the relevant plan agreement.

| Benefit | Essential Care plan |
|---|---|
| The overall maximum limit that you can claim during any one period of cover | US\$250,000 |
| Hospital costs | |
| Hospital accommodation | ○ Full cover |
| Hospital treatment | ○ Full cover |
| Parent accommodation | ○ Full cover |
| Road ambulance | ○ Cover up to US\$1,200 per period of cover |
| In-patient emergency restorative dental treatment | ○ Cover up to US\$5,000 per period of cover |
| Cancer treatment | |
| Cancer treatment, including chemotherapy, radiotherapy, immunotherapy, consultations, tests, scans, and drugs. Cover for out-patient cancer treatment is limited to a period of 5 years from the later date of the surgery, or the completion of, chemotherapy or radiotherapy. | ○ Full cover |
| Cancer genome tests | ○ Cover up to US\$2,000 per period of cover |
| Organ, bone marrow or tissue transplants | |
| Transplant and related treatment | ○ Full cover |
| Donor costs | ○ Cover up to US\$25,000 per transplant |
| Kidney dialysis | |
| Short-term kidney dialysis of up to 4 weeks | ○ Full cover |

Key ○ Full cover within annual plan benefit limit ○ Partial or limited cover

| Benefit | Essential Care plan |
|---|---|
| Reconstructive surgery | |
| Surgery to restore your appearance after an accident, or after surgery for breast cancer | ○ Cover for in-patient, day-patient and post-hospital treatment received within the 90 day period following the date you are discharged from hospital |
| Congenital abnormalities or hereditary conditions | |
| Treatment aimed to cure a congenital abnormality, 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 | ○ Cover for in-patient, day-patient and post-hospital treatment received within the 90 day period following the date you are discharged from hospital only, within the 'Annual sub-limit for out-patient treatment', up to a lifetime limit of US\$20,000 |
| HIV/AIDS treatment | |
| Treatment for a maximum period of 5 years (24-month waiting period) | ○ Cover up to US\$1,000 per period of cover |
| Prosthetic implants | |
| Surgically-implanted, artificial body parts as an essential part of surgical operation | ○ Full cover |
| Everyday medical costs | |
| Annual sub-limit for out-patient treatment | US\$2,500 |
| Primary medical care | ○ Cover for post-hospital treatment received within the 90 day period following the date you are discharged from hospital |
| Out-patient surgical procedures | ○ Full cover |
| Advanced diagnostic tests | ○ Cover for post-hospital treatment received within the 90 day period following the date you are discharged from hospital |
| Physiotherapy | ○ Cover up to US\$250 for post-hospital treatment received within the 90 day period following the date you are discharged from hospital only, up to US\$1,000 per period of cover |
| Chronic conditions | |
| Acute flare-ups | ○ Cover for in-patient, day-patient and post-hospital treatment received within the 90 day period following the date you are discharged from hospital only, within the 'Annual sub-limit for out-patient treatment' |
| Terminal illnesses | |
| Palliative and/or Hospice care, and care for persistent vegetative state | ○ Cover up to a lifetime limit of US\$25,000 |

Key ○ Full cover within annual plan benefit limit ○ Partial or limited cover

| Benefit | Essential Care plan |
|------------------------------------|-------------------------|
| Expat benefits | |
| Medevac | ○ Full cover |
| 24 medical assistance helpline | ○ Full cover |
| Return airfare | ○ Full cover |
| Travelling expenses of a companion | ○ Full cover |
| Repatriation of mortal remains | ○ Cover up to US\$5,000 |
| Burial or cremation | ○ Cover up to US\$1,600 |

Key ○ Full cover within annual plan benefit limit ○ Partial or limited cover