Benefit		Bronze	Silver	Gold Plus
Lifetime Maximum per Individual Insured Person		$2.5M	$5M	$5M
A. In-Patient & Day-Patient Treatment				
1	Surgery, Surgeons, Consultants, Second Surgical Opinion, Medical Practitioners, Nurses, Treatment, Services and Supplies routinely provided and Ancillary Charges	Full Cover	Full Cover	Full Cover
2	Hospitalization / Room & Board		Up to $600 per day 240 day Maximum	
3	Intensive Care Unit		Up to $1500 per day – 180 day per event	
4	Anaesthetist’s Charges associated with Surgery		20% of Surgery Benefit	
5	Diagnostic Tests and Procedures, X-Rays, Pathology, & MRI/CT Scans			
6	Prescribed Drugs, Dressings and Durable Medical Equipment			
7	Re constructive Surgery - following an accident or following surgery for an eligible condition			
8	Cancer Tests, Drugs, Treatment and Consultants, including cover for Chemotherapy and Radiotherapy			
9	Physiotherapy			
10	Parental Hospital Accommodation			
11	Prosthetic Devices			

Benefit		Bronze	Silver	Gold Plus
12	Transplants	$250,000 Per Transplant	$250,000 Per Transplant	$1,000,000 Lifetime Limit
13	State Hospital Cash Benefit	$300 Per Night, 60 nights	$300 Per Night, 60 nights	$300 Per Night, 60 nights
B. Out-Patient Treatment, Wellness Benefits and Other Coverages				
1	Out-Patient including: Family Doctor, Treatment and Referrals, Specialists and Consultants, X-Rays, Pathology, Diagnostic Tests and Procedures *not dependent upon admission	No Family Doctor Cover Specialists & Consultants: Up to $500 Prior to admission*, then Up to $500 following related Out-Patient Surgery or In-Patient treatment for 90 days after leaving hospital Including Pre* & Post Hospital: $250 X-Ray per Examination Maximum Limit; $300 Lab Tests per Examination Maximum Limit	25 Visit Maximum Maximum Per Visit: Examination: $70 Doctor/ Specialist $60 Psychiatrist $250 X-ray per Examination Maximum Limit $500 Surgery Intervention Consultation $300 Lab Tests per Examination Maximum Limit	Full Cover
2	Emergency Room Illness, Waived if admitted as an In-Patient or Day-Patient (Additional $250/£138/€168 Deductible if not admitted)	No Cover	Full Cover	Full Cover
3	Emergency Room Accident	No Cover	Full Cover	Full Cover
4	Supplemental Accident	No Cover	No Cover	$300 per

Benefit		Bronze	Silver	Gold Plus
	Benefit			covered accident
5	Out-Patient Surgery	Full Cover	Full Cover	Full Cover
6	MRI, CAT Scan, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy, Cystoscopy	$600 Maximum Per Examination	$600 Maximum Per Examination	Full Cover
7	Cancer Tests, Drugs, Treatment and Consultants, including cover for Chemotherapy and Radiotherapy	Full Cover	Full Cover	Full Cover
8	Prescribed Out-Patient Drugs, Medicines, Dressings and Durable Medical Equipment	Up to $600 Following and in relation to In-Patient Treatment or Out-Patient Surgery for 90 days after leaving hospital	Full Cover	Full Cover
9	Physiotherapy, Homeopathic, Chiropractic Therapy and Osteopathic Therapy	Physiotherapy Only: Relating to In-Patient Treatment, Out-Patient Surgery Up to $40 per visit 10 visit Maximum for 90 days after leaving hospital	Up to $40 / £25 / €30 per visit 30 visit Maximum	Up to $50 per visit Maximum of 1 visit per day Maximum of 1 visit per day 45 visit Maximum
10	Complementary Medicine Acupuncture, Aroma Therapy, Herbal Therapy,	No Cover	No Cover	Up to $200

Benefit		Bronze	Silver	Gold Plus
	Magnetic Therapy, Massage Therapy, Vitamin Therapy, Traditional Chinese Medicine			
11	AIDS/HIV Treatment			Up to $5000 per Period of Insurance $50,000 Lifetime Limit
12	Home Nursing Care	30 Days Limit: Up to $150 per visit	30 Days Limit: Up to $150 per visit	45 Days Limit: Up to $150 per visit
13	Rehabilitation	No Cover	No Cover	Full Cover Up to 90 Days
14	Extended Care Facility		Full Cover Up to 30 Days	
15	Hospice Care	No Cover	No Cover	Full Cover Up to 180 Days
16	Adult Wellness and Health Check - includes Hearing Test, Sight Test and Vaccinations/Inoculations (Not subject to Annual Deductible or Co-Insurance) - After 12 months continuous coverage (6 months on Platinum)	No Cover	No Cover	Up to $250 Available for those 30 years of age and over
17	Child Wellness and Health Check (Under 18 years of age) - includes Hearing Test, Sight Test and Vaccinations/Inoculations (Not subject to Annual Deductible or Co-Insurance) No Cover No Cover - After 12 months continuous coverage	No Cover	3 visits per Period of Insurance Up to $70 per visit	Up to $200

Benefit		Bronze	Silver	Gold Plus
	(6 months on Platinum)			
18 a	Pre-Existing Medical Conditions Full Medical Underwriting Option*: - After 24 months continuous cover - Declared and Accepted conditions (unless otherwise excluded or terms applied as indicated otherwise in writing) - Flexible Underwriting Option available – refer to page 24	No Cover	Up to $5000 $50,000 Lifetime Limit	Up to $5000 $50,000 Lifetime Limit
or 18 b	Moratorium Enrolment & Underwriting Option* - After 24 months continuous coverage: subject to 24 months without treatment, symptoms, medication or consultation* - Available to insured up to age 54		Full Cover	Full Cover
*Cover in respect of Pre-Existing Conditions is as selected at time of application and identified on your Certificate of Insurance. Refer to page 23 for further details and Policy Wording for full Policy definitions, terms, conditions and restrictions.				
19	Newly Diagnosed Chronic Conditions	Full Cover	Full Cover	Full Cover
20	Mental/Nervous - After 12 months continuous coverage	No Cover	Out-Patient Only - See Section B1	Up to $10,000 $50,000 Lifetime Limit
C. Travel, Transportation and Out of Area Benefits				
1	Emergency Local Ambulance	Up to $1,500 per event *Not subject to Annual Deductible or Co-Insurance*	Up to $1500 per event *Not subject to Annual Deductible or Co-Insurance*	Full Cover
2	Emergency Evacuation and Transportation To the Nearest Suitable Hospital	Up to $50,000 *Not subject to*	Up to $50,000 *Not subject to*	Full Cover *Not subject to*

Benefit		Bronze	Silver	Gold Plus
	Facility	*Annual Deductible or Co-Insurance*	*Annual Deductible or Co-Insurance*	*Annual Deductible or Co-Insurance*
3	Accompanying Relative, Travel and Accommodation	No Cover	No Cover	$10,000 Lifetime Limit
4	Cremation/Burial or Return of Mortal Remains	$10,000 Lifetime Limit *Not subject to Annual Deductible or Co-Insurance*	$25,000 Lifetime Limit *Not subject to Annual Deductible or Co-Insurance*	$25,000 Lifetime Limit *Not subject to Annual Deductible or Co-Insurance*
5	Remote Transportation - For additional transport for on-going Treatment once stabilised	No Cover	No Cover	No Cover
6	Security & Political Evacuation & Repatriation	No Cover	No Cover	No Cover
7	Worldwide Accident & Emergency Out of Area Coverage (USA Treatment Must be within PPO Network)	15 Days Maximum	30 Days Maximum	30 Days Maximum
D. Dental Treatment & Vision Care Benefits				
1	Emergency Dental Due to Accident	Up to $1,000	Up to $1,000	Full Cover
2	Emergency Dental due to Sudden Unexpected Pain To Sound Natural Teeth	No Cover	No Cover	Up to $100
Non-Emergency Dental Benefits * Refer To Policy Wording/Endorsement for Full Details & Listing		Optional Add-On Coverage - Additional Premium Applies * Coverage is issued via a Dental & Visions Care Coverage Endorsement Sections D1 & D2 above are replaced with:		
1	Emergency Dental Due to Accident	Full Cover		
2	Emergency Dental due to Sudden Unexpected Pain To Sound Natural Teeth	Up to $100		
3	Non-Emergency Dental - Sections D4, D5 &	i) $750: ii) $50:		

Benefit		Bronze	Silver	Gold Plus
	D6 Combined: i) Calendar Year Maximum Sum Insure ii) Dental Annual Deductible iii) Maximum Annual Deductiblees per Family per Calendar Year - After 6 months continuous cover	iii) 2		
4	Class I Treatment*: - Preventative & Diagnostic - Emergency Palliative Treatment - Includes up to two dental check ups per calendar year to include scraping, cleaning and polishing. - After 6 months continuous cover * Refer To Policy Wording for Full Details & Listing	90% Coverage, Dental Annual Deductible Waived		
5	Class II Treatment*: - Radiographs & X-Rays - Oral Surgery & Extractions - Routine Compound Fillings, Restorations, Re- cementing crowns, inlays and bridges & Prosthetic Repairs - Endodontics & Root Canals - Periodontics & Gum Disease - Minor Restorative Services - After 6 monthscontinuous cover * Refer To Policy Wording for Full Details & Listing	70% Coverage, after Dental Annual Deductible		
6	Class III Treatment*: - Prosthodontic Services including: appliances, bridges, full and partial dentures that replace missing natural teeth that were extracted while the person is covered with this Plan	50% Coverage, after Dental Annual Deductible		

Benefit		Bronze	Silver	Gold Plus
	- Major Restorative Treatment including: Crowns, Jackets, gold-related services required when teeth can not be restored using other filling material. - After 6 months continuous cover * Refer To Policy Wording for Full Details & Listing			
Vision Care Benefits * Refer To Policy Wording/Endorsement for Full Details & Listing		Optional Add-On Coverage - Additional Premium Applies * Coverage is issued via a Dental & Visions Care Coverage Endorsement Sections D1 & D2 above are replaced with:		
7	Vision Care Not subject to Annual Deductible or Co-Insurance (Benefit payable per 24 months)	Exams – up to $100 Materials – up to $150		
E. Additional Benefits & Services				
1	High School Sports Injury	No Cover		
2	Recreational Scuba	No Cover	Full Cover	Full Cover
3	Medical Information Service	Not Applicable		
4	Global Concierge & Assistance Services			
5	24 Hour Emergency Helpline	Included		
F. Maternity				
Maternity - Only available to Female Insureds - After 10 months of continuous cover *All benefits reduced by 50% for births occurring in the 11th or 12th month of continuous coverage		Optional Add-On Coverage Additional Premium Applies*		
Maternity Annual Deductible		Section F1 & F2 : Not subject to Annual Deductible or Co-Insurance		

Benefit		Bronze	Silver	Gold Plus
Lifetime Maximum		*$50,000 Lifetime Limit		
1	Normal Delivery - Including Premature Birth Treatment, Pre, Post and Routine Natal Care	*Up to $5000		
2	C-Section	*Up to $7500		
3	Newborn Baby Wellness - Not subject to Annual or Annual Maternity Deductible or Co-Insurance - for the first 12 months of life	$200		
4	Cover for Newborns including non-hereditary birth defects and congenital abnormalities	*Up to $250,000 for the first 31 days		
Annual Deductible and Co-Insurance				
Annual Deductible Options - Per Insured Person, Per Period of Insurance		Nil $250 to $10,000		
		50% waived (up to a maximum reduction of $2500 / for: USA PPO Out-Patient & Emergency In-Patient Treatment & Non-Emergency In-Patient USA Medical Concierge Provider Treatment		
Family Maximum Annual Deductiblees		3 x Individual Annual Deductible		
Annual Deductible Carry Forward - If prior Annual Deductible not met, then last 30 days Expenses from the previous Period of Insurance are carried forward and applied towards satisfying the Annual Deductible for the next Period of Insurance		Yes		
Co-Insurance within the USA &		No Co-Insurance		

Benefit	Bronze	Silver	Gold Plus
Canada PPO Network			
Co-Insurance outside the USA and Canada			
Co-Insurance Payable by Insured inside the USA and Canada* – When treatment is taken outside the USA & Canada PPO Network - (*No Co-Insurance for Non-Emergency In-Patient Treatment when utilising a USA Medical Concierge Provider)	20% of the next $5000 eligible expenses after the Annual Deductible, then No Co-Insurance to the overall maximum per Period of Insurance		