Benefits Schedule

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BENEFITS SCHEDULE

The benefits schedule provides a summary of the cover provided per ***period of insurance*** unless stated otherwise. Terms in italics refer to defined terms. The meaning to these defined terms can be found in the definitions section of the policy terms and conditions. All limits and monetary amounts shall in all instances be in US$. All the claims must be ***reasonable and customary***. TeleHEALTH services are included. Services rendered in USA must be within our preferred network except for ***emergency***. Otherwise, 40% co-insurance will be applied.

HOSPITAL AND SURGERY PLANS
One of these plans must be selected to form the basis of your cover

ANNUAL LIMIT	ESSENTIAL	EXTENSIVE	ELITE
The overall limit per person per ***period of insurance***	$1,500,000	$2,500,000	$4,500,000
HOSPITAL **NETWORK** The ***hospitals*** where ***you*** may receive treatment as per the benefits listed in ***your*** Hospital and Surgery Plan	Standard: Free choice of provider Optional: For treatment in Singapore and Hong Kong, ***Specified Inpatient Providers*** only*		
HOSPITAL BENEFITS ***Pre-authorisation*** is required for the following services			
Hospital room and board	*Double Occupancy Room / Single Occupancy Room* *Double Occupancy Room* option is only available to Hong Kong resident		
Intensive Care Unit	Fully Covered		
Parental accommodation	Fully Covered		
Theatre fees	Fully Covered		
Blood, dressings, ***medicines and drugs***	Fully Covered		
Surgical implants	Fully Covered		
Diagnostic scans and tests, including ***invasive endoscopic examinations***	Fully Covered		
Rental of ***mobility aids***	Fully Covered		
Orthopaedic braces, supports and air boots	Fully Covered		
Professional fees	Fully Covered		
Hospital treatment of ***mental and nervous conditions***	Fully covered up to 30 days		Fully covered up to 60 days
PRE-HOSPITALISATION BENEFITS			
Pre-hospitalisation benefits before admission for a covered ***confinement***	No Cover	Fully covered up to 30 days before a covered ***confinement***	Fully covered up to 180 days before a covered ***confinement***
POST-HOSPITALISATION BENEFITS			
Post-hospitalisation benefits following a covered ***confinement***	No Cover	Fully covered up to 90 days after a covered ***confinement***	Fully covered up to 180 days after a covered ***confinement***
ADULT PREVENTIVE SCREENING			
Adult preventive screening as follows: (***We*** cover the screenings only. The associated consultation cost will not be covered) ▸ Mammography for women aged 40 years and above ▸ Pap smear for women aged 19 and above ▸ Prostate screening for men aged 40 years and above **For members who buy an Outpatient module, cover for this benefit will be provided as per the sum stated on the Outpatient module**	$250 Panel Network Providers Only		

* The Specified Inpatient Providers list is available at http://healthbyapril.com/specified-hospitals

HOSPITAL AND SURGERY PLANS - CONTINUED

ORGAN TRANSPLANTATION	ESSENTIAL	EXTENSIVE	ELITE
Organ transplantation	*Hospital* Benefits, *Pre-hospitalisation Benefits*, *Post-hospitalisation Benefits* sections apply		
Direct ***expenses*** of ***surgery*** to remove an organ for transplant from a donor	$50,000		
PRIVATE NURSING, HOME NURSING			
Private nursing in ***hospital*** when certified necessary by attending ***physician***	No Cover	Fully Covered	Fully Covered
Home nursing prescribed by attending ***physician***	No Cover	$135 per day up to 30 days	$225 per day up to 90 days
HOSPITAL CASH BENEFIT			
Where ***you*** are hospitalised for a covered ***confinement*** at no cost to ***us***.	$100 per night up to a maximum of 45 nights	$200 per night up to a maximum of 45 nights	$400 per night up to a maximum of 45 nights
Where ***you*** are hospitalised in ward for a covered confinement in a private or public ***hospital***.			
REHABILITATION TREATMENT *Pre-authorisation* is required for this benefit			
Rehabilitation treatment received while an inpatient at a ***rehabilitation centre***. Admission to the ***rehabilitation centre*** must take place within 2 weeks after discharge from ***hospital*** for a covered ***confinement***.	Up to 60 days	Up to 80 days	Up to 185 days
EXTERNAL PROSTHESIS			
External prosthesis and any services associated with selection, fitting or repair	$1,000	$2,000	$4,000
SURGERY OR INVASIVE ENDOSCOPIC EXAMINATION PERFORMED WHILE A DAY-PATIENT, IN A CLINIC,OR IN A PHYSICIAN'S OFFICE			
Professional fees, ***diagnostic scans and tests***, ***medicines and drugs*** including five post-surgical follow ups. Also covers the following on the day of, and directly related to, the ***surgery*** or ***invasive endoscopic examination***: ***hospital room and board***, theatre fees, dressings, ***medicines and drugs***, pathology fees, and ***surgical implants***. This benefit does not cover the following unless Outpatient Benefits are purchased: laryngoscopy, nasopharyngoscopy, otoscopy; any ***surgery*** on the skin and subcutaneous tissue for ***illness*** other than ***surgery*** following a confirmed diagnosis of cancer.	Fully covered		
CANCER TREATMENT The following services, when directly related to cancer, shall be covered following a confirmed diagnosis of cancer.			
Hospital treatment of cancer	*Hospital* Benefits section applies		
Specialist consultations; ***diagnostic scans and tests***; ***medicines and drugs***; chemotherapy, radiotherapy and target therapy related to ***active cancer treatment***	Fully covered		
KIDNEY DIALYSIS			
Kidney dialysis received while admitted to ***hospital*** or out of ***hospital***	$50,000	Fully Covered	
HIV/AIDS			
All-inclusive lifetime limit for services rendered in connection with *HIV/AIDS* including antiretroviral treatment, treatment of primary HIV, testing and monitoring, or treatment of AIDS. *HIV/AIDS* waiting period of 3 years prior to ***your*** first positive HIV test result, or the date ***you*** received any treatment for *HIV/AIDS* (or following possible exposure to the virus), whichever is later (Policy Terms and Conditions Section 8.1.4)	$50,000 lifetime benefit	$100,000 lifetime benefit	Fully Covered

HOSPITAL AND SURGERY PLANS - CONTINUED

EMERGENCY ROOM TREATMENT	ESSENTIAL	EXTENSIVE	ELITE
EMERGENCY* ROOM TREATMENT** Treatment as a result of an ***injury within 48 hours of an ***accident***; or acute exacerbation of a ***disability*** which requires urgent medical or surgical intervention to avoid permanent damage to ***your*** life or health	Fully Covered		
WALK-IN *EMERGENCY* ROOM TREATMENT Walk-in ***Emergency*** Room Treatment which does not lead to ***confinement*** or not related to an ***accident***	$250	$300	$600
EMERGENCY DENTAL TREATMENT			
Emergency ***dental treatment*** to repair damage to sound natural teeth within 14 days of ***accident***	Fully Covered		
LOCAL TRANSPORT BY AMBULANCE			
Transport by ambulance to and from ***hospital*** prescribed by an attending ***physician***	Fully Covered		
HOSPICE OR PALLIATIVE TREATMENT			
Hospice or palliative treatment	$25,000 lifetime benefit	$50,000 lifetime benefit	$100,000 lifetime benefit
SPECIAL LIMITS APPLYING TO CERTAIN DISABILITIES			
Subject to the benefits and sub-limits stated elsewhere in this ***benefits schedule,*** the maximum ***we*** will pay for losses directly or indirectly arising from the following ***disabilities*** is as stated below.			
Chronic Conditions	Fully Covered		
Complications of pregnancy	No Cover	Fully Covered	
Congenital and hereditary conditions lifetime per person	No Cover	$100,000 lifetime benefit	$200,000 lifetime benefit
Neonatal ***disabilities*** lifetime per person (applicable only to children added under Section 9.1) Newborn Addition waiting period of 366 days prior to the date of birth applies (Policy Terms and Conditions Section 8.1.2)	No Cover	$100,000 lifetime benefit	$200,000 lifetime benefit
Stem Cell Treatment, including harvesting immediately prior to a treatment	No Cover	$75,000 lifetime benefit	$150,000 lifetime benefit
AREA OF COVER			
Area of Cover Options	Worldwide; Worldwide Excluding ***USA***		
Out of Area Cover	Services rendered outside of the area of cover are covered up to $100,000 ***per period of insurance*** only if they are directly caused by ***sudden illness*** or ***injury*** occurring during the first 30 travel days of any trip outside the area of cover. ***Sudden illness*** or ***injury*** does not include any ***disability*** of which symptoms existed prior to the start of the trip and which would have caused a reasonable person to seek medical care. This benefit does not apply for any trip commenced or continued against the orders or advice of any ***physician*** or other medical practitioner; or undertaken in whole or in part for the purpose of obtaining medical care.		
ANNUAL DEDUCTIBLE			
Only applies to the ***Hospital*** and ***Surgery*** Plan	Nil $1,500 $3,000 $5,000 $10,000		

OUTPATIENT PLANS

The following Outpatient modules are optional and can be combined with any ***Hospital and Surgery*** Module

ANNUAL LIMIT FOR OUTPATIENT BENEFITS	ESSENTIAL	EXTENSIVE	ELITE
Annual cumulative limit for all benefits shown in the Outpatient Benefits section	Option 1 : Upon overall limit - with 20% ***co-insurance percentage*** Option 2 : $7,000 with nil ***co-insurance percentage***	Up to overall limit per ***period of insurance***	
CO-INSURANCE PERCENTAGE			
Outpatient ***co-insurance percentage***	Option 1: 20% Option 2: Nil	Choice of nil or 20%	
	Co-insurance is waived at ***panel network*** providers only for direct billing services upon e-card presentation.		
Direct Billing	Direct Billing available at ***panel network*** providers only	***Co-insurance*** is waived at ***panel network*** providers only for direct billing services upon e-card presentation. If nil co-insurance is selected, you can access to general network with direct billing service upon ecard presentation.	
GENERAL PRACTITIONER & SPECIALIST CONSULTATION FEES			
General Practitioner consultation fees	Fully Covered		
Specialist consultation fees	Fully Covered		
Physiotherapy A ***referral*** for ***physiotherapy*** must be submitted at the same time as ***your*** claim. Treatment is limited to 10 sessions per ***referral*** after which a new ***referral*** and medical report from your attending ***physician*** must be submitted. The ***referral*** requirement is waived for the first 3 sessions ***per period of insurance***	$1,000	Fully Covered	
OUTPATIENT MENTAL AND NERVOUS CONDITIONS			
Physician, psychologist, psychotherapist and ***complementary medicine practitioners'*** consultation fees, ***diagnostic scans and tests, medicines and drugs*** prescribed by a ***physician*** for ***mental and nervous conditions***	No Cover	$2,500	$5,000
OUTPATIENT BEHAVIOURAL AND DEVELOPMENTAL DISORDERS			
Physician, psychologist and psychotherapist consultation fees, ***diagnostic scans and tests, medicines and drugs*** prescribed by a ***physician*** for a ***behavioural or developmental disorder***	No Cover	$1,000	$1,500
MEDICINES AND DRUGS			
Medicines and drugs	Fully Covered		
DIAGNOSTIC SCANS AND TESTS			
Diagnostic scans and tests	Fully Covered		
MEDICAL APPLIANCES AND MOBILITY AIDS			
Purchase or rental of ***mobility aids*** Slings and bandages Purchase or rental of ***medical appliances***	$2,000 Maximum two ***mobility aids*** per ***disability***	$3,500 Maximum two ***mobility aids*** per ***disability***	$7,000 Maximum two ***mobility aids*** per ***disability***

OUTPATIENT PLANS - CONTINUED

COMPLEMENTARY MEDICINE AND TRADITIONAL CHINESE MEDICINE May use non-panel providers with no penalty	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
Combined limit for all benefits listed in the ***Complementary Medicine*** and Traditional Chinese Medicine section	$750	$1,750	$5,000
Consultation fees for the following complementary medicine practitioners, upon ***referral***: Dietician following ***illness*** or ***injury***, occupational therapy No ***referral*** required: Chiropractor, osteopath, podiatrist, speech therapist following ***illness*** or ***injury***	Fully covered Up to the combined limit		
Consultation fees and medicine/consumables dispensed or used by the following practitioners in the course of treatment: Acupuncturist, bone setter, Chinese medicine practitioner, naturopath, homeopath, Ayurveda practitioner, ***hypnotherapist*** No ***referral*** required.	Fully covered Up to the combined limit		
	Maximum one consultation per day		
FOLLOW UP CANCER CARE			
These services shall be covered following the completion of ***active cancer treatment***: ***Medicines and drugs*** prescribed to prevent a recurrence of cancer and related specialist consultations.	Fully Covered		
SCREENING, MEDICAL CHECKUP AND VACCINATIONS			
Adults preventive screening as follows: ▸ Mammography for women aged 40 years and above ▸ Pap smear for women aged 19 and above ▸ Prostate screening for men aged 40 years and above	$250	$400	Fully Covered
		One of each test per ***period of insurance*** ***Panel Providers*** Only	
Child health screenings below 16 years old for evaluating medical history, physical and development assessment, school entry health check and or diabetic screening.		$400	Fully Covered
		Age 3 and below : Maximum two tests per period of insurance Age 4 to 16 : Maximum one test per period of insurance	
Medical checkup packages or standalone tests or scans not listed above which are conducted in the absence of a diagnosis or suspected diagnosis No ***referral*** required		$750	$2,000
Vaccinations (cost of vaccination only. Associated GP consult covered under consultation benefit) No ***referral*** required			
ROUTINE OUTPATIENT MATERNITY			
Physician consultation fees, ***diagnostic scans and tests***, ***medicines and drugs, vitamins and supplements,*** prescribed by a ***physician*** or licensed midwifery practice or clinic for routine pre-natal and post-natal services up to 45 days following birth Waiting period 8.1.1 of the Policy Terms and Conditions	No Cover		$5,000 per pregnancy

DENTAL AND OPTICAL BENEFIT

Available to anyone who has selected a ***Hospital and Surgery*** module

	ESSENTIAL	EXTENSIVE	ELITE
Minor Dental treatment	$1,250		
Major Dental treatment Including orthodontic treatment commenced below the age of 16. Waiting period of 300 days to the data of service applies (Policy Terms and Conditions Section 8.1.3)	No Cover	$2,500	
Eye examinations, frames, prescription contact lenses and prescription lenses	No Cover		$300

MATERNITY MODULE

Available to women between 19 to 45 years of age who have selected an Extensive or Elite ***Hospital and Surgery*** on a nil ***deductible*** basis, plus an optional Outpatient module.

	ESSENTIAL	EXTENSIVE	ELITE
Maternity Benefit limit	$5,000 per pregnancy	$10,000 per pregnancy	$15,000 per pregnancy
The following prenatal and post-natal services up to 45 days following birth: ***Physician*** consultation fees, ***diagnostic scans and tests***, ***medicines and drugs***, licensed midwifery and certified doula services, vitamins and supplements, complementary medicine ,complementary maternity therapies (without ***referral***). Delivery, including elective and emergency caesarean sections and up to seven (7) days of ***nursery care***. Complications of pregnancy following ***major or minor assisted conception*** Therapeutic abortions. Please refer to waiting period in terms and conditions	Fully Covered Up to the overall maternity limit		
Maternity Cash Benefit Where ***you*** deliver ***your*** infant at no cost to ***us*** and the infant is added to ***your*** policy	$1,000 per delivery	$2,000 per delivery	$3,000 per delivery

REPATRIATION, EVACUATION AND ASSISTANCE SERVICES PROVIDED BY APRIL ASSISTANCE

In the event of an emergency, the Member may call-collect our dedicated assistance hotline 24 hours a day, 365 days a year to request the following services. All limits and monetary amounts are stated in US$ and cover is subject to our policy terms and conditions. For more details, please refer to the Emergency Assistance Program scope of services.

IN THE EVENT OF ACCIDENT OR SUDDEN SEVERE ILLNESS OF THE MEMBER (To a combined limit of US$1,000,000)	**Included in every plan**
Emergency medical evacuation and medically required repatriation	Fully Covered
Return of the member to the ***country of residence*** after recovery	Return economy class airline ticket
Compassionate visit (if the member is unaccompanied and hospitalisation is reasonably expected to be more than 7 days)	Economy round trip transportation & hotel accommodation Up to $150 per night for a maximum of 7 nights
Supply and delivery of medication not available locally	Fully Covered
Return of member's family members	One-way economy class airline ticket
Return of dependants	One-way economy class airline ticket
Round the clock telephone access	Trained multilingual personnel including a medical team will be on-hand to assist
IN THE EVENT OF THE DEATH OF THE MEMBER (To a combined limit of US$30,000)	
Repatriation of mortal remains	Fully Covered
Cost of a transport coffin for repatriation of the body by air	Up to $5,000
Presence of a person to accompany the deceased	Economy round trip transportation & hotel accommodation Up to $150 per night for a maximum of 7 nights
Return of insured family members	One-way economy class airline ticket
IF PERSONAL EFFECTS ARE LOST OR STOLEN ABROAD	
Cash advance outside ***your home country*** or ***country of residence***	Included
Sending urgent messages	Included
IN THE EVENT OF AN UNINTENTIONAL INFRACTION OF THE LAW ABROAD	
Advance of legal expenses occurred while abroad	Included
Advance of cost of bail while abroad	Included
Assistance with translation of legal or administrative documents	Up to $500 per event
Referral to local legal advisors	Included
IN THE EVENT OF THE DEATH OR CRITICAL ILLNESS OF A FAMILY MEMBER	
Compassionate Home Travel	Return economy class airline ticket up to $1,000
OTHER TRAVEL ASSISTANCE SERVICES	
APRIL Assistance will provide the following travel-related information	Visa and inoculation requirements for foreign countries Lost luggage and passport assistance while the member is traveling outside his/her ***Home Country*** or Usual ***Country of Residence***
MEDICAL ASSISTANCE	
Medical Referral Service	Access to a global network of appointed and credentialed doctors, specialists and ***hospitals***
Hospital Admission including Admission Deposits	In the event of an ***emergency*** admission, ***we*** will make arrangements to issue a ***hospital*** letter of guarantee
Tele-medicine Consultation and Evaluation of the Member's Condition	APRIL Assistance's duty doctors will provide help over the phone
Medical Monitoring	APRIL Assistance will monitor a Member's condition if hospitalised abroad

For more information, contact your insurance consultant :

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