Benefits Schedule

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INSURANCE MADE EASY

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BENEFITS SCHEDULE

The *benefits schedule* summarises the cover provided per *period of insurance* unless stated otherwise. Terms in italics refer to defined terms. The meaning of 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 the *USA* must be within *our* preferred network except for *emergencies*. Otherwise, 40% *co-insurance* will be applied.

ANNUAL LIMIT	**CORE**	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
The overall limit per person per *period of insurance*	$400,000	$2,000,000	$3,000,000	$4,000,000
AREA OF COVER				
Area of Cover Options	ASEAN Excluding Singapore	Worldwide Worldwide Excluding *USA* ASEAN Excluding Singapore		
Out of Area Cover	Covered only for *Accident* up to $100,000	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.		
	Nil	For members under ASEAN Excluding Singapore: *We* cover inpatient treatment in *your home country* for Australian or European nationals, subject to a 20% co-insurance. 40% co-insurance for treatments non pre-authorised by *us* No co-insurance for *sudden illnesses*		
***HOSPITAL* AND *SURGERY* PLANS** One of these plans must be selected to form the basis of *your* cover				
	CORE	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
***HOSPITAL* BENEFITS** *Pre-authorisation* is required for the following services				
Hospital room and board	*Single Occupancy Room*			
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 for up to 10 days		Fully covered for up to 20 days	Fully covered for up to 30 days

***HOSPITAL* AND *SURGERY* PLANS – CONTINUED**				
***PRE-HOSPITALISATION* BENEFITS**	**CORE**	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
Pre-hospitalisation benefits before admission for a covered *confinement*	Fully covered up to 15 days before a covered *confinement*	Fully covered up to 30 days before a covered *confinement*		Fully covered up to 60 days before a covered *confinement*
***POST-HOSPITALISATION* BENEFITS**				
Post-hospitalisation benefits following a covered *confinement*	Fully covered up to 15 days after a covered *confinement*	Fully covered up to 30 days after a covered *confinement*	Fully covered up to 60 days after a covered *confinement*	Fully covered up to 90 days after a covered *confinement*
ORGAN TRANSPLANTATION				
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		
Home nursing prescribed by attending *physician*	No Cover			$135 per day up to 30 days
***HOSPITAL* CASH BENEFIT**				
Where *you* are hospitalised for a covered *confinement* at no cost to *us*	$100 per night	$150 per night	$200 per night	$250 per night
Hospital cash benefit is not available if *you* claim for services rendered during the hospitalisation	Up to a maximum of 30 nights per *period of insurance*			
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 15 days	Up to 30 days	Up to 60 days	Up to 90 days
EXTERNAL PROSTHESIS				
External prosthesis and any services associated with selection, fitting or repair	No Cover	$1,000	$2,000	$3,000
***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 two 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.				
Active Cancer treatment in *Hospital*	*Hospital* Benefits sections apply			
Specialist consultations, *diagnostic scans and tests, medicines and drugs,* chemotherapy and radiotherapy related to *active cancer treatment*	Fully covered			

***HOSPITAL* AND *SURGERY* PLANS – CONTINUED**				
KIDNEY DIALYSIS	**CORE**	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
Kidney dialysis received while admitted to *hospital* or out of *hospital*	$50,000	Fully covered		
HIV/AIDS				
All-inclusive 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 applies (please refer to the Terms and Conditions)*	No Cover	$5,000 per *period of insurance*	$20,000 per *period of insurance*	$30,000 per *period of insurance*
***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			
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	$10,000 lifetime benefit	$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	No Cover		$100,000 lifetime benefit	$200,000 lifetime benefit
Neonatal disabilities lifetime per person Applicable only to Newborn Additions *(please refer to the Terms and Conditions)*	No Cover		$100,000 lifetime benefit	$200,000 lifetime benefit
ANNUAL *DEDUCTIBLE*				
Only applies to the *Hospital and Surgery* Plan	Nil	Nil $500 $1,000 $2,500 $5,000 $10,000		

OUTPATIENT PLANS
The following Outpatient modules are optional. Core outpatient may be purchased with core *Hospital and Surgery* Module only.
All other modules may be bought in all combinations.

ANNUAL LIMIT FOR OUTPATIENT BENEFITS	CORE	ESSENTIAL	EXTENSIVE	ELITE
Annual cumulative limit for all benefits shown in the Outpatient Benefits section	$2,500	$5,000	Up to overall limit per *period of insurance*	
CO-INSURANCE PERCENTAGE				
Outpatient *co-insurance percentage*	Choice of Nil or 20%			
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*.	Fully Covered			
OUTPATIENT *MENTAL AND NERVOUS CONDITIONS*				
Physician or *psychologist* consultation fees, *diagnostic scans and tests*, *medicines and drugs* prescribed by a *physician* for *mental and nervous conditions*	No Cover	$2,000	$3,500	$5,000
MEDICINES AND DRUGS				
Medicines and drugs	Fully Covered			
Prescribed Vitamins and Minerals	No Cover		$150	
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*	$250	$500	$2,000	$3,500
	Maximum two *mobility aids* per *disability*			
***COMPLEMENTARY MEDICINE* AND TRADITIONAL CHINESE MEDICINE**				
Combined limit for all benefits listed in the *Complementary Medicine* and Traditional Chinese Medicine section	$250	$500	$1,500	$3,000
Consultation fees for the following *complementary medicine* practitioners: Chiropractor, dietician, osteopath, podiatrist, speech therapist following *illness* or *injury*. No *referral* required.	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, Ayurveda practitioner, homeopath, bone setter, Chinese medicine practitioner, No *referral* required	Up to $50 per visit		Up to $75 per visit	Up to $150 per visit
	Maximum one consultation per day Up to the combined limit			

OUTPATIENT PLANS – CONTINUED				
FOLLOW UP CANCER CARE	**CORE**	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
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			
***MEDICAL CHECKUP* AND VACCINATIONS**				
Medical checkup including standalone screenings, e.g. mammography, prostate screening No *referral* required	No Cover		$400	$800
Vaccinations No *referral* required	No Cover		$100	$500

DENTAL AND OPTICAL BENEFIT Available to anyone who has selected a *Hospital and Surgery* module				
	CORE	**ESSENTIAL**	**EXTENSIVE**	**ELITE**
Minor dental treatment	$300		$1,000	
Major dental treatment, including orthodontic treatment commenced below the age of 16. A *waiting period* of 300 days applies *(please refer to the Terms and Conditions)*	No Cover		$2,500	
Eye examinations, 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	$8,000 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 maternity therapies (without *referral*) Delivery, including elective and *emergency* caesarean sections and up to seven (7) days of nursery care *Complications of pregnancy* following assisted conception *Complications of childbirth* *Therapeutic abortions* A *waiting period* of 366 days applies *(please refer to the Terms and Conditions)*	Fully Covered Up to the overall maternity limit		

REPATRIATION, EVACUATION AND ASSISTANCE SERVICES PROVIDED BY APRIL ASSISTANCE

In the event of an *emergency*, the Member may call *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 Dollars (USD) and cover is subject to *our* policy terms and conditions. For more details, please refer to the *Emergency Assistance* Program scope of services.

ANNUAL LIMIT	INCLUDED IN EVERY PLAN
The overall limit per person per *period of insurance*	$1,000,000
In the event of *accident* or sudden severe *illness* of the member Limited to one (1) *emergency* evacuation and/or repatriation attributable to any single medical condition by a **Member**	
Medical evacuation or medical transport to the ***nearest adequate registered hospital***	100%
Compassionate Visit Limited to one (1) claim per **Member**	One-way transport ticket (first class train, standard economy flight or other available means deemed appropriate by **APRIL Assistance**)
Return to the place of residence after recovery	One-way transport ticket (first class train, standard economy flight or other locally available means deemed appropriate by **APRIL Assistance**) for ***You*** to return to ***Your Place of Residence***
Return of immediate family members (up to 3 persons)	One-way transportation ticket (first class train, standard economy class flight or any other locally available means deemed appropriate by **APRIL Assistance**) for them to return to ***Your place of residence***
Return of dependent children	One-way transportation ticket (first class train, standard economy class flight or any other locally available means deemed appropriate by **APRIL Assistance**) for them to return to ***Your Place of Residence***, or the place of residence of the nearest relative or designated guardian where appropriate.
Assistance in the event of the death of the member (To a combined limit of $30,000)	
Repatriation of mortal remains	100%
Cost of one (1) transport coffin for repatriation of body by air	Up to $5,000
Presence of one person to accompany the deceased	Round trip transportation (first class train, standard economy class flight or any other locally available means deemed appropriate by **APRIL Assistance**) plus up to 7-night accommodation in a hotel limited to $150 per night (if the visitor does not have any accommodation) for one (1) person designated by ***your* immediate family**.
Return of family members (up to 3 persons)	One-way transportation ticket (first class train, standard economy class flight or any other locally available means deemed appropriate by **APRIL Assistance**) for them to return to **their Place of Residence**
Legal assistance Abroad	
Advance of cost of bail bond	Included
Assistance with translation of legal or administrative documents	Up to $500
Death or Critical *illness* of a family member	
Compassionate Home Travel	One-way transport ticket by air in standard economy or by train in 1st class for 1 member on the contract

MH INDO BI 2025/04

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PAHAMI & MILIKI ASURANSI

Terdaftar dan diawasi oleh OJK OTORITAS JASA KEUANGAN

April International