International Healthcare Plan

Benefits Schedule

$ - Plus

Effective 1 April, 2012

In the table below, **we** have displayed the **benefits** applicable to **your cover**.

To help **you** understand **your cover**, the words and phrases that are in bold in **your policy documentation** have specific meanings, and are defined in the IHP member handbook.

The following **benefits** are covered under this **policy** up to the maximum aggregate limit subject to the **benefit** limits in this schedule, the applicable medical underwriting, the **member's certificate of insurance** and **our** general conditions and exclusions.

General exclusions include: alcohol, drug or solvent abuse, **chronic medical conditions** that pre-date the **member's** original **date of entry**, cosmetic **treatment**, sexually transmitted diseases, sterilisation and **elective** medical checkups.

All **benefits** shown are per **insured person**, per **period of cover** (unless specifically stated), and the selected **policy excess** applies to all **benefits** on a per **medical condition** basis (unless specifically stated).

	Plus
Maximum Annual Aggregate Limit	A maximum of $1,600,000 per **member** per **period of cover**
Inpatient, Day Patient, Emergency Care and Diagnostics	
Inpatient Care **Reconstructive Surgery and Rehabilitation**	Covered in full i) Accommodation is subject to any selected inpatient bed limit ii) **Rehabilitation** is covered in full up to 120 days per **medical condition**
Accident & Emergency Treatment Outside Area of Cover	Covered in full for **inpatient treatment** **Outpatient treatment** is limited to $500 per **medical condition** and subject to an **excess** of $80 per **medical condition**
CT PET and MRI Scans	Covered in full
Organ Transplant	Covered in full
Inpatient Psychiatric Treatment	Covered in full (up to 30 days) per **period of cover**
Accidental Damage to Teeth	Covered in full
Hospital Cash	Up to $175 per night for a maximum of 20 nights per **medical condition**
Parental Accommodation	Covered in full
Disease and Chronic Conditions Management	
Oncology	Covered in full
Chronic Conditions	Up to $15,000 per **insured person** per **period of cover**
Congenital Anomalies	Up to $100,000 per **medical condition**
Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS)	Up to $1,000 per **medical condition**
AIDS	Up to $10,000 per **insured person** per **period of cover**
Hospice Care	Up to $25,000 per lifetime
Hormone Replacement Therapy	Covered in full up to 18 months per lifetime
Outpatient and Alternative Treatments	
Outpatient Care	Covered in full
Outpatient Surgery	Covered in full
Outpatient Psychiatric Treatment	Up to $5,000 per **period of cover**
Alternative Treatment	Covered in full up to 20 sessions in aggregate per **medical condition**
Vaccinations and Inoculations	Up to $500 per **period of cover**
Home Nursing	Covered in full up to 28 weeks per **medical condition**
Evacuation and Transportation	
Emergency Transportation	Covered in full

	Plus
Evacuation & Additional Travel Expense i) **Travel** ii) **Non-hospital accommodation**	i) Covered in full ii) Up to $150 per person per day and $5,000 per person, per **evacuation**
Compassionate Emergency Travel	No cover
Mortal Remains	Up to $8,500 per **insured person**
Mother and Child	
Complications of Pregnancy	Covered in full
New Born Care	Up to $100,000 per **insured person** per **period of cover** and to a maximum of 90 days **hospital** stay
New Born Accommodation	Covered in full
Options to Reduce Costs	
China Private Room Restriction	Covered in full
Hong Kong Semi-Private Room Restriction	Covered in full
Outpatient Consultation Copay per Visit This **benefit** is available where nil **excess** has been selected.	USD$15 **copay per visit** or **deductible.** *OR* USD$20 **copay per visit** or **deductible.** *OR* USD$30 or **copay per visit** or **deductible.**
Inpatient Bed Limit	**Inpatient** bed limit $75 per day *OR* **Inpatient** bed limit $150 per day *OR* **Inpatient** bed limit $200 per day *OR* **Inpatient** bed limit $250 per day *OR* **Inpatient** bed limit $375 per day *OR* **Inpatient** bed limit $500 per day
Options to Upgrade Cover	
Alternative Treatment without Medical Referral	Up to $1,000 per **insured person** per **period of cover** *OR* Up to $2,000 per **insured person** per **period of cover**
Chronic Conditions	Covered in full
Compassionate Emergency Travel	Up to $3,000 per **period of cover**
Complications of Pregnancy – no wait period	Covered in full

	Plus
Congenital Anomalies - Including Pre-existing Congenital Anomalies	Covered in full *OR* Up to $100,000 per **medical condition** *OR* Up to $250,000 per **medical condition**
Dental 1 - Routine Dental Treatment	Up to $250 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $250 per **period of cover** and no **coinsurance** *OR* Up to $500 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $500 per **period of cover** and no **coinsurance** *OR* Up to $750 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $750 per **period of cover** and no **coinsurance** *OR* Up to $1,000 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $1,000 per **period of cover** and no **coinsurance** *OR* Up to $1,500 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $2,000 per **period of** $2,000 or SGD$2,500 or **cover** and subject to 25% **coinsurance** *OR* Up to $2,500 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $1,500 per **period of cover** and no **coinsurance** *OR* Up to $2,000 per **period of cover** and no **coinsurance** *OR* Up to $2,500 per **period of cover** and no **coinsurance**

	Plus
Dental 2 - Major Restorative Dental Treatment	Up to $500 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $500 per **period of cover** and no **coinsurance** *OR* Up to $750 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $750 per **period of cover** and no **coinsurance** *OR* Up to $1,000 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $1,000 per **period of cover** and no **coinsurance** *OR* Up to $1,500 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $2,000 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $2,500 per **period of cover** and subject to 25% **coinsurance** *OR* Up to $1,500 per **period of cover** and no **coinsurance** *OR* Up to $2,000 per **period of cover** and no **coinsurance** *OR* Up to $2,500 per **period of cover** and no **coinsurance**
Dental 3 - Orthodontic Dental Treatment	Up to $500 per **period of cover** and subject to 50% **coinsurance** *OR* Up to $1000 per **period of cover** and subject to 50% **coinsurance** *OR* Up to $1,500 per **period of cover** and subject to 50% **coinsurance** *OR* Up to $1,500 per **period of cover** and no **coinsurance** *OR* Up to $500 per **period of cover** and no **coinsurance** *OR* Up to $1000 per **period of cover** and no **coinsurance**
Dental 5 - Combined Routine & Restorative Dental	Up to $1,500 per **period of cover** and no **coinsurance** *OR* Up to $1,500 per **period of cover** and subject to 25% **coinsurance**

	Plus
Dental 6 - Combined Routine & Restorative Dental with Orthodontics	Up to $2,500 per **period of cover** and no **coinsurance** *OR* Up to $2,500 per **period of cover** and subject to 25% **coinsurance**
Dental 7 - Combined Routine & Restorative Dental with Orthodontics and Dental Implants	Up to $3,000 per **period of cover** and no **coinsurance** *OR* Up to $3,000 per **period of cover** and subject to 25% **coinsurance**
Outpatient Direct Settlement Network - nil excess This benefit is available where a Nil, $50 *OR* $100 **policy excess** has been selected.	**Outpatient** consultations are available on a nil **excess** basis where **treatment** is received in network. Where **outpatient** consultations take place outside the **direct settlement network** the **policy excess** applies.
Extended Evacuation (to the country of choice)	Covered in full
Out of Country Transportation For **medically necessary** non-emergency **treatment** as an **inpatient** or **day patient** i) Travel ii) Non-**hospital** accommodation	i) Covered in full ii) Up to $150 per person per day and $5,000 per person, per **evacuation** *OR* Up to $250 per person per day and $10,000 per person, per **evacuation**
Infertility Treatment (minimum of 10 Employees required)	Up to $25,000 per **member** per lifetime
Routine Pregnancy	Up to $5,000 per pregnancy and subject to 20% **coinsurance** *OR* Up to $5,000 per pregnancy and no **coinsurance** *OR* Up to $10,000 per pregnancy and subject to 20% **coinsurance** *OR* Up to $10,000 per pregnancy and no **coinsurance** *OR* Up to $20,000 per pregnancy and subject to 20% **coinsurance** per pregnancy *OR* Up to $20,000 per pregnancy and no **coinsurance** *OR* Covered in full per pregnancy but subject to 20% **coinsurance** *OR* Covered in full per pregnancy with no **coinsurance**

	Plus
Traditional Chinese or Ayurvedic Medicine	$30 per session to a maximum of 10 sessions *OR* $30 per session to a maximum of 20 sessions *OR* $50 per session to a maximum of 30 sessions *OR* Up to $500 per **period of cover** *OR* Up to $750 per **period of cover**
USA Elective Treatment i) **Inpatient** or **day patient treatment** received inside the **direct settlement network** ii) **Inpatient** or **day patient treatment** received outside the **direct settlement network** iii) **Outpatient treatment** The International Healthcare Plan (IHP) does not comply with the Patient Protection and Affordable Care Act (U.S. healthcare reform), and cannot be used to satisfy any requirements for health insurance **cover** mandated therein.	i) Covered in full ii) Up to $1,000,000 per **member** per **period of cover** and subject to 50% **coinsurance** iii) Covered in full
Vision Care	One eye exam and a maximum **benefit** of up to $250 per **period of cover** *OR* One eye exam and a maximum **benefit** of $500 per **period of cover** *OR* One eye exam and a maximum **benefit** of $750 per **period of cover**
Wellness Option 1 Routine medical checkups & well-baby checks	Up to $250 per **insured person** per **period of cover**
Wellness Option 2 Bilateral mammogram/breast examination and routine gynaecological tests including PAP tests Testicular/prostate examination/PSA/DRE tests Routine medical checkups Well-baby checks	Up to $500 per **insured person** per **period of cover** *OR* Up to $750 per **insured person** per **period of cover** *OR* Up to $1,000 per **insured person** per **period of cover** *OR* Up to $1,500 per **insured person** per **period of cover**
Wellness Option 3 Preventive Screening Preventive screening for **members** who are deemed at high risk	Up to $1,000 per **insured person** per **period of cover** *OR* Up to $1,500 per **insured person** per **period of cover**

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