



WorldCare Members' Handbook | Product Summary

Aviation Affinity Plan



Everything you need to know about your international health insurance

Effective 1 November 2014

Introduction

Thank you for choosing Now Health International to provide **Your** international health insurance **Plan**.

We have designed WorldCare based on **Our** understanding of what people who buy international health insurance want and need. At the heart of this is **Our** commitment to provide clear information about how **Your Plan** works and how to use it. Please read this handbook carefully to ensure that **You** are completely satisfied that the cover provided under **Your** chosen **Plan** meets **Your** needs.

How to use this handbook

This handbook is an important document. It sets out **Your** rights and **Our** obligations to **You**. Along with the **Benefit Schedule** in section 5, it explains **Your** chosen WorldCare **Plan** and the terms of **Your** cover.

Inside **You** will find details of:

- The cover **You** have (both **Benefits** and exclusions)
- **Your** rights and responsibilities
- How to make a claim
- How **Your Plan** is administered
- How to make a complaint
- Other services available to **You** under **Your Plan**

Throughout the handbook certain words and phrases appear in bold type. This indicates that they have a special medical or legal meaning – these are defined in section 1.

The **Benefits** of **Your Plan** are detailed in section 5 of this handbook. **Your Certificate of Insurance** shows the cover that is available, **Your** period and level of cover. As with any healthcare insurance contract, there are exclusions. These are **Medical Conditions** and **Treatments** that are not covered – they are listed in section 6 of this handbook.

Our service for You

When **You** need to use **Your** Now Health insurance, here's what **You** can expect from **Us**:

- A commitment to process **Your** claim as quickly as possible
- A 24-hour help line for medical emergencies
- Help to find suitable healthcare providers in **Your** area
- **Pre-authorisation** of certain claims where possible, to reduce **Your** out-of-pocket expenses
- An international claims management team with the medical expertise to support **You** in making decisions about **Your** healthcare

If **You** require more details about this **Plan**, or if **You** would like to tell **Us** about any changes in **Your** personal circumstances, please contact **Us** using the details on the next page.

Contacting Us

While it is important that **You** read and understand this **Plan** members' handbook, **We** understand that there are times when it is easier to call **Us** for information. **Our** customer service team is ready to help with any queries **You** may have. For example, if **You** need **Treatment**, **You** can contact **Us** first so **We** can explain the extent of **Your** cover before **You** incur any costs.

Please note that **We** may record and/or monitor calls for quality assurance and training and as a record of **Our** conversation. If **You** need to let us know about any changes in **Your** personal circumstances, **You** can do so using the contact details below.

Our team is available Monday to Friday from 9am to 5pm.

T +65 6880 2300 | F +65 6220 6950 | SingaporeService@now-health.com

Now Health International (Singapore) Pte. Ltd.

c/o Tenet Sampo Insurance Pte. Ltd.

50 Raffles Place

#05-01/06 Singapore Land Tower

Singapore 048623

Health at Hand

Available 24 hours a day, 365 days a year. For details on **Our** health information service see section 4.

T +65 6880 2305

Assistance team for Emergency Evacuation or Repatriation

Our multilingual team is available 24 hours a day, 365 days a year. For details on how to use **Our Emergency Evacuation** and **Repatriation** service see section 3.3.

T +65 6880 2304

If **You** have any questions about **Your** membership or would like to request information on the progress of a claim, **You** can log in to **Your** online secure portfolio at www.now-health.com or contact **Us** via email at SingaporeService@now-health.com.

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1. Definitions

The following words and phrases used anywhere within **Your Plan** have specific meanings. They are always shown in bold with a capital letter at the beginning wherever they appear in **Your Plan**.

Accident	A sudden, unexpected, unforeseen and involuntary external event resulting in identifiable physical injury occurring to an Insured Person while Your Plan is in force.
Acute Condition	A disease, illness or injury that is likely to respond quickly to Treatment which aims to return You to the state of health You were in immediately before suffering the disease, illness or injury, or which leads to Your full recovery.
Act of Terrorism	Any clandestine use of violence by an individual terrorist or a terrorist group to coerce or intimidate the civilian population to achieve a political, military, social or religious goal.
Agreement	An agreement We have with each of the Hospitals , Day-Patient units and scanning centres listed in the Now Health International Provider Network .
Alternative Therapies	Refers to therapeutic and diagnostic Treatment that exists outside the institutions where conventional medicine is taught. Such medicine includes Chinese medicine, chiropractic Treatment , osteopathy, dietician, homeopathy and acupuncture as practiced by approved therapists.
Apicoectomy	Is a dental surgery performed to remove the root tip and the surrounding infected tissue of an abscessed tooth, when inflammation or infection persists in the bony area around the end of a tooth after a root canal procedure. Apicoectomy is done to treat the following: <ul style="list-style-type: none"> • Fractured tooth root • A severely curved tooth root • Teeth with caps or posts • Cyst or infection which is untreatable with root canal therapy • Root perforations • Recurrent pain and infection • Persistent symptoms that do not indicate problems from x-rays • Calcification • Damaged root surfaces and surrounding bone requiring surgery
Benefits	Insurance cover provided by this Plan and any extensions or restrictions shown in the Certificate of Insurance or in any endorsements (if applicable) and subject always to Us having received the premium due.
Benefit Schedule	The table of Benefits applicable to this Plan showing the maximum Benefits We will pay.
Cancer	A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
Certificate of Insurance	The certificate giving details of the Planholder , the Insured Persons , the Period of Cover , the Underwriters , the Entry Date , the level of cover and any endorsements that may apply.
Congenital Disorder	A Medical Condition that is present at birth or is believed to have been present since birth, whether it is inherited or caused by environmental factors.
Co-Insurance	Is the uninsured percentage of the costs, which the Insured Person must pay towards the cost of a claim.
Country of Nationality	The country for which You hold a passport.
Country of Residence	The country in which You habitually reside (usually for a period of no less than six months per Period of Cover) at the Plan Start Date or Entry Date or at each subsequent Renewal Date .

Chronic Condition	<p>A disease, illness or injury which has at least one of the following characteristics:</p> <ul style="list-style-type: none"> • It needs ongoing or long-term monitoring through consultations, examination, check-ups, Drugs and Dressings and/or tests • It needs ongoing or long-term control or relief of symptoms • It requires Your Rehabilitation or for You to be specially trained to cope with it • It continues indefinitely • It has no known cure • It comes back or is likely to come back
Day-Patient	A patient who is admitted to a Hospital or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.
Dental Practitioner	A person who is legally licensed to carry out this profession by the relevant licensing authority to practise dentistry in the country where the dental Treatment is given.
Dependants	<p>One spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with You, or up to 28 years old if in full-time education (written proof may be required from the educational institute where they are enrolled), at the Start Date or any subsequent Renewal Date. The term partner shall mean husband, wife, civil partner or the person permanently living with You in a similar relationship. All dependants must be named as Insured Persons in the Certificate of Insurance.</p>
Diagnostic Tests	Investigations, such as x-rays or blood tests, to find or to help to find the cause of Your symptoms.
Drugs and Dressings	Essential prescription drugs, dressings and medicines administered by a Medical Practitioner or Specialist needed to relieve or cure a Medical Condition .
Eligible	Those Treatments and charges, which are covered by Your Plan . In order to determine whether a Treatment or charge is covered, all sections of Your Plan should be read together, and are subject to all the terms (including payment of premium due), Benefits and Exclusions set out in this Plan .
Entry Date	The date shown on the Certificate of Insurance on which an Insured Person was included under this Plan .
Emergency	A sudden, serious, and unforeseen acute Medical Condition or injury requiring immediate medical Treatment , that without Treatment commencing within 48 hours of the emergency event could result in death or serious impairment of bodily function.
Evacuation or Repatriation Service	<p>Moving You to a Hospital which has the necessary In-Patient and Day-Patient medical facilities either in the country where You are taken ill or in another nearby country (evacuation) or bringing You back to either Your principal Country of Nationality or Your principal Country of Residence (repatriation). The service includes any Medically Necessary Treatment administered by the international assistance company appointed by Us while they are moving You.</p>
Excess	An uninsured amount payable by an Insured Person in respect of expenses incurred before any Benefits are paid under the Plan , as specified in Your Certificate of Insurance . The Plan excess applies per Insured Person , per Medical Condition , per Period of Cover .
Expatriate	Any persons living and/or working outside of the country for which they hold a passport. Usually for a period of more than 180 days per Period of Cover .
Geographic Area	The geographic area used to calculate the premium that will apply to You based on Your principal Country of Residence at the Start Date or any subsequent Renewal Date of this Plan .

Hospital	Any establishment, which is licensed as a medical or surgical hospital under the laws of the country where it operates. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.
Hospital Accommodation	Refers to standard private or semi-private accommodation as indicated in the Benefit Schedule . Deluxe, executive rooms and suites are not covered.
In Network Medical Provider	An in network medical provider is one contracted with Your Plan to provide services to Plan members for specific pre-negotiated rates.
In-Patient	A patient who is admitted to Hospital and who occupies a bed overnight or longer, for medical reasons.
Insured Person/You/Your	The Planholder and/or the Dependants named on the Certificate of Insurance who are covered under this Plan .
Medical Condition	Any disease, injury, or illness, including Psychiatric Illness .
Medical Practitioner	A person who has attained primary degrees in medicine or surgery following attendance at a WHO -recognised medical school and who is licensed to practise medicine by the relevant authority in the country where the Treatment is given. By "recognised medical school" We mean a medical school, which is listed in the current World Directory of Medical Schools published by the WHO .
Medically Necessary	Treatment , which in the opinion of a qualified Medical Practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the Insured Person's condition or the quality of medical care rendered. Such Treatment must be required for reasons other than the comfort or convenience of the patient or Medical Practitioner and provided only for an appropriate duration of time. As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to In-Patient Treatment , medically necessary also means that diagnosis cannot be made, or Treatment cannot be safely and effectively provided on an Out-Patient basis.
New Born	A baby who is within the first 16 weeks of its life following birth.
Now Health International Provider Network	Our published list of medical providers where We have a Direct Billing Agreement.
Out of Network Medical Provider	An out of network medical provider is one not contracted with Your Plan .
Out-Patient	A patient who attends a Hospital , consulting room, or out-patient clinic and is not admitted as a Day-Patient or an In-Patient .
Out-Patient Direct Billing	This is an option available for all but the Essential Plan option that allows You to maintain the standard Plan Excess of USD 100. When You receive Eligible Out-Patient Treatment within Our direct billing network of providers however, a nil Excess will apply. Any Eligible Out-Patient Treatment outside of the direct billing network will be subject to the Plan Excess applicable per Insured Person , per Medical Condition , per Period of Cover . You remain liable for Treatment received that is not Eligible , which must be settled on request. If You do not act accordingly Your Plan will become void without refund of premium.
Period of Cover	The period of cover set out in the Certificate of Insurance . This will be a 12-month period starting from the Start Date or any subsequent Renewal Date as applicable.
Physiotherapist	A practising physiotherapist who is registered and licensed to practise in the country where Treatment is provided.

Pre-Authorisation	A process whereby an Insured Person seeks approval from Us prior to undertaking any Treatment or incurring costs. Such Benefits requiring pre-authorisation from Us will denote Pre-Authorisation in the Benefit Schedule and as detailed in section 5.
Plan	The contract between You and Us which set out terms and conditions of the cover provided. The full terms and conditions consist of the application form, Certificate of Insurance , Benefit Schedule and this members' handbook.
Planholder	The person or company named as planholder in the Certificate of Insurance .
Pregnancy	Refers to the period of time from the date of the first diagnosis until delivery.
Private Room	Single occupancy accommodation in a private Hospital . Deluxe, executive rooms and suites are not covered.
Psychiatric Illness	The mental or nervous disorder that meets the criteria for classification under an international classification system such as Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation.
Related Conditions	A Related Condition is any disease, injury or illness including Psychiatric Illness that is caused by a Pre-Existing Medical Condition or results from the same underlying cause as a Pre-Existing Medical Condition .
Qualified Nurse	A nurse whose name is currently on any register or roll of nurses, maintained by any Statutory Nursing Registration Body within the country where Treatment is provided.
Reasonable and Customary Charges	The standard fee that would typically be made in respect of Your Treatment costs, in the country You received Treatment . We may require such fees to be substantiated by an independent third party, such as a practising Surgeon/Physician/ Specialist or government health department.
Rehabilitation	Medically Necessary Treatment aimed at restoring independent activities of daily living and the normal form and/or function of an Insured Person following a Medical Condition .
Renewal Date	The anniversary of the Start Date of the Plan .
Semi-Private Room	Dual occupancy accommodation in a private Hospital . Deluxe, executive rooms and suites are not covered.
Specialist	A surgeon, anaesthetist or physician who has attained primary degrees in medicine or surgery following attendance at a WHO -recognised medical school and who is licensed to practise medicine by the relevant authority in the country where the Treatment is given, and is recognised as having a specialised qualification in the field of, or expertise in, the Treatment of the disease, illness or injury being treated. By "recognised medical school" We mean a medical school which is listed in the current World Directory of Medical Schools published by the WHO .

Start Date	The start date shown on Your Certificate of Insurance . We must have received premium payment in order for Your contract to start.
Surgical Procedure	An operation requiring the incision of tissue or other invasive surgical intervention.
Terminal	Following the diagnosis that the condition is terminal and Treatment can no longer be expected to cure the condition with death anticipated within 12 months of diagnosis.
Treatment	Surgical or medical services (including Diagnostic Tests) that are needed to diagnose, relieve or cure a Medical Condition .
Underwriters	Those insurance companies named as underwriters in the Certificate of Insurance . Tenet Sompo Insurance Pte. Ltd. is the underwriter.
Vaccinations	Refers to all basic immunisations and booster injections required under regulation of the country in which Treatment is being given, any Medically Necessary travel vaccinations and malaria prophylaxis.
Waiting Period	Is a period of time starting on Your Plan Start Date (or Entry Date if You are a Dependant), during which You are not entitled to cover for particular Benefits . Your Benefit Schedule will indicate which Benefits are subject to waiting periods.
We/Our/Us	Now Health International (Singapore) Pte. Ltd. on behalf of the Underwriters detailed in the Certificate of Insurance . Plans are underwritten by Tenet Sompo Insurance Pte. Ltd.
WHO	The World Health Organisation.

2. Manage your plan online

A guide to the Now Health website

The simplest way to manage **Your** international health insurance is via our website (www.now-health.com). All **Your** documents are stored in a secure online portfolio area, which **You** can access using **Your** unique username and password. If **You** need help retrieving these, contact us on +65 6880 2300.

Quote and buy

You can manage **Your** own quote and sale process by choosing, buying and paying for **Your Plan** online. There's no need to fill in any paper forms, and **Your** cover can start as soon as **We** have accepted **You**. **We** will send **You Your Plan** number and a virtual membership card immediately and **You** can access **Your Plan** documents online straight away.

About You

In this section, **You** can view and update **Your** personal contact details and login details and set **Your** document delivery settings.

Your Plan

You can view and download **Your Certificate of Insurance**, members' handbook, virtual membership card and claim form from here. **You** can add members, order replacement membership cards, and when it's time, renew your cover.

Your claims

Here **You** can find out the best way to make a claim and track **Your** current claims in real time. **You** can view information about all your claims, past and present, including claim status, the provider and the amounts claimed and settled in the currency **You** have selected. All updates are displayed as they happen so **You** always have the latest information on **Your** claims.

Other features

In addition to the above, **You** can use the website to contact **Us** directly, download forms and introduce **Us** to **Your** medical provider.

For more information, visit the FAQ section of the website, which **You** can access from **Our** homepage: www.now-health.com.

3. How to claim

As soon as **You** become a customer, **You** can contact **Our** Customer Service team for support. **You** also have access to **Our** Clinical Advisers and **Our** International Emergency Helpline, which is open 24 hours a day, 365 days a year.

Your online secure portfolio area has a dedicated claims section with the latest information on past and present claims. **You** can also use this area to find out the most up-to-date way of making a claim.

To log in, **You** just need **Your** Now Health username and password.

To help **Us** process **Your** claim as quickly as possible, please follow these simple steps:

3.1 Claiming for Treatment You have already paid for

Step 1

Choose how **You** would like to claim

You can complete an online claim form at www.now-health.com. Claim forms are available in **Your** online secure portfolio area. Alternatively, **You** can download a claim form to send to **Us** or use a printed claim form. **You** can request a form from **Our** customer service team, or **Your** intermediary, if **You** are using one.

Call **Us** on +65 6880 2300 to request a printed claim form, or if **You** would like help to access **Your** online secure portfolio area.

Step 2

For claims under USD 500 per Medical Condition:

Complete sections 1 and 2 of the claim form, sign it, and email it to **Us** with **Your** scanned receipt.

The receipt must include details of the **Medical Condition**, **Treatment** given and the name, qualifications, contact details and stamp of the attending **Medical Practitioner**.

Step 2

For claims over USD 500 per Medical Condition:

Complete all sections of the claim form, sign it and ask **Your Medical Practitioner** to complete their relevant section and email it to **Us** with **Your** scanned receipt.

We need **You** to email scanned copies of all the bills and receipts, diagnostic reports and discharge reports (if **You** have been a **Day-Patient** or **In-Patient**) with the claim form. Please keep a copy of these documents for **Your** own records.

Step 3

You can send **Us** **Your** completed claim form and supporting documents in one of three ways:

- Download a claim form from the website and email scans of **Your** claim form and documents to SingaporeService@now-health.com, or
- Fax **Your** claim form and documents to +65 6220 6950, or
- Post **Your** claim form and documents to Now Health International (Singapore) Pte. Ltd. c/o Tenet Sompso Insurance Pte. Ltd. 50 Raffles Place, #05-01/06 Singapore Land Tower, Singapore 048623

Step 3

You can send **Us** **Your** completed claim form and supporting documents in one of three ways:

- Download a claim form from the website and email scans of **Your** claim form and documents to SingaporeService@now-health.com, or
- Fax **Your** claim form and documents to +65 6220 6950, or
- Post **Your** claim form and documents to Now Health International (Singapore) Pte. Ltd. c/o Tenet Sompso Insurance Pte. Ltd. 50 Raffles Place, #05-01/06 Singapore Land Tower, Singapore 048623

Step 4

We will assess **Your** claim. Provided **We** have all the information **We** need, **We** will process all **Eligible** claims within five working days of receipt.

Step 5

You can track all **Your** claims using **Your** online secure portfolio area.

Log in at any time using **Your** username and password to see how **Your** claim is progressing. **You** will be able to view the status, the provider, the currency claimed and settled and the **Benefit** for each individual claim, as well as any **Excess** or **Co-Insurance** deducted. All updates are displayed as they happen so **You** always have the latest information on **Your** claims. **We** will email or SMS **You** every time there is a change to the claims status on **Your** account so **You** know the most relevant time to log in.

Important notes:

You must send **Us** **Your** claim within six months of **Treatment** (unless this is not reasonably possible).

Please keep original records if **You** are sending **Us** a copy, as **We** may ask **You** to forward these at a later date.

If **We** do, it will be within six months of when **You** told **Us** about the claim.

If the total amount **You** are claiming now or have claimed (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500, please ensure Section 3 of the claim form is completed by the treating **Medical Practitioner**.

If **You** don't know if **Your** claim falls within the USD 500 per **Medical Condition** guideline, please complete all sections of the claim form and ask **Your Medical Practitioner** to complete their section send it to **Us** to using one of the options in Step 3.

For all claims where **We** reimburse **You**, **You** can choose which currency **You** would like **Your** claims to be settled in and how **You** would like them to be paid.

Please note that the above process applies to claims against both the maternity and dental **Benefits**, should **You** have opted for a **Plan** with those **Benefits**.

3.2 Arranging Direct Settlement

3.2.1 For In-Patient and Day-Patient Treatment

If **You** are referred for **In-Patient** or **Day-Patient Treatment**, **We** will try to arrange to settle the bill directly with the medical provider.

Step 1

Five working days before **You** are admitted (or whenever possible), contact **Our** team of Clinical Advisers on
T +65 6880 2300 | F +65 6220 6950 | SingaporeService@now-health.com

Tell **Us** the **Hospital** name, telephone number, fax number, the contact name at the **Hospital** and the name of the **Medical Practitioner**.

Step 2

Choose how **You** would like to claim.

You can complete an online claim form at www.now-health.com. Claim forms are available within **Your** online secure portfolio area.

Alternatively, **You** can download a claim form to send to **Us** or use a printed claim form. **You** can request a form from **Our** customer service team, or **Your** intermediary, if **You** are using one.

Call **Us** on +65 6880 2300 to request a printed claim form, or if **You** would like help to access **Your** online secure portfolio area.

Complete all relevant sections of the claim form. Take the claim form with **You** and ask the medical provider to complete it and fax it to **Us**.

Step 3

When **You** arrive at the medical provider on the day of **Your Treatment**, show **Your** membership card and tell them that **Direct Billing** has been arranged.

We may also ask **You** to fill in some extra forms, such as a release of medical information by the medical provider. **You** can access all the forms **You** need from **Your** online secure portfolio area at www.now-health.com.

You will need to pay any **Excess** or **Co-Insurance** on **Your Plan** to the medical provider before **You** leave.

Step 4

When **You** leave, ask the medical provider to send the original claim form and bill to **Us** for payment. **You** can track all subsequent claims activity in **Your** online secure portfolio area. Log in using **Your** username and password at www.now-health.com.

Important notes:

For **In-Patient Treatment**, **Day-Patient Treatment** or major **Out-Patient Treatment**, please contact **Us** before **You** get **Treatment**. If **You** don't make contact before **Your** admission, **We** may not be able to arrange to pay the medical provider directly. This might mean that **You** have to pay a deposit to the medical provider or pay **Your** bill in full.

If **You** need repeat **In-Patient** or **Day-Patient Treatment**, **We** need a new claim form for each stay, even if it's for the same **Medical Condition**.

You will need to pay any **Excess** or **Co-Insurance** on **Your Plan** to the medical provider before **You** leave.

3.2 Arranging Direct Settlement

3.2.2 Out-Patient Treatment within the Now Health International Direct Billing Network

If **You** have a nil **Excess** or **You** have bought the **Out-Patient Direct Billing** product option, **You** can receive **Treatment** without having to pay the medical provider upfront through **Our Out-Patient Direct Billing Network**. If **You** have this option, it will say so on **Your** membership card.

Any **Eligible Out-Patient Treatment** outside of the **Out-Patient Direct Billing Network** will be subject to the **Plan Excess** **You** have chosen.

Please note that if **You** have selected **Co-Insurance Out-Patient** charges, **You** must pay the 20% **Co-Insurance** even if a nil **Excess** applies and **Out-Patient Direct Billing** is available. **Out-Patient Direct Billing** is not available if **You** have chosen the WorldCare Essential **Out-Patient** Charges additional option and **You** have a nil **Excess**.

Step 1

To find an **Out-Patient Direct Billing** facility, log in to **Your** online secure portfolio area at www.now-health.com. Here **You** can locate an appropriate medical facility within the **Out-Patient Direct Billing Network**.

If **You** can't find an **Out-Patient Direct Billing** facility near **You**, **Our** team of Clinical Advisers will be happy to help.

You can contact them on T +65 6880 2300 | F +65 6220 6950 | SingaporeService@now-health.com



Step 2

When **You** arrive at the medical facility, please show **Your** Now Health membership card. Please also take a form of identification such as an ID card or passport. The medical facility may ask **You** to complete and sign an authorisation form or disclaimer.



Step 3

The medical facility will check **Your Benefit** limits, **Excess** and any **Co-Insurance** before arranging for **You** to see a doctor. If **Your** cover is not **Eligible**, they will still arrange for **You** to see a doctor but will ask **You** to pay for the **Treatment**.



Step 4

When **You** leave, the medical facility may ask **You** to sign a confirmation that **You** have received **Treatment**.



Step 5

If **You** need to return for further **Treatment**, **You** will have to complete the same procedure again.

Important notes:

If **You** receive **Treatment** that is not **Eligible** under **Your Plan** through the **Out-Patient Direct Billing** option, **You** are liable for the costs incurred and **You** must refund **Us**. **We** may offset valid claims against outstanding funds due to **Us** or **We** may suspend **Your Plan** until **You** have settled the outstanding amounts in full. If **We** determine that a claim was fraudulent, **We** may terminate **Your Plan** with immediate effect without refund of premiums.

3.3 When You need Emergency medical Treatment

If a **Hospital** admits **You** for **Emergency** medical **Treatment** or if the **Hospital** that is treating **Your Emergency Medical Condition** tells **You** that **You** need to be evacuated to another medical facility for **Treatment**, **You**, the treating **Medical Practitioner** or the **Hospital**, must contact **Our** 24 hour **Emergency** assistance service as soon as possible.

By contacting **Our Emergency** assistance service **You** will give **Us** the opportunity to arrange to settle **Your Hospital** bills directly where possible. It will also ensure that **Your** claim can be processed without any delays.

Step 1

Contact **Our Emergency** assistance service on +65 6880 2304 or email SingaporeService@now-health.com. This service is available 24 hours a day, 365 days a year.

They will need **Your** name and membership number as well as the **Hospital** name, telephone number and fax number, a contact name at the **Hospital** and the name of the **Medical Practitioner**.

Step 2

Our Emergency assistance service will verify whether the **Medical Condition** **You** are claiming for is **Eligible** under **Your Plan**.

Step 3

If **Your** claim is **Eligible**, **Our Emergency** assistance service staff will consider **Your Emergency** admission or **Your** request for **Evacuation** in relation to **Your** medical needs.

Step 4

If **Our Emergency** assistance service agrees that **Your Medical Condition** meets all of the following:

- is life-threatening
- is covered by **Your Plan**
- cannot be treated adequately locally, and
- requires immediate **In-Patient Treatment**

They will make all the necessary arrangements to have **You** moved by air and/or surface transportation to the nearest **Hospital** where appropriate medical **Treatment** is available.

Our Emergency assistance service will also ensure that any **Eligible** costs at the destination, such as admission costs, are settled directly with the **Hospital**.

Step 5

Once **You** have received **Your** medical **Treatment**, if **Our Emergency** assistance service agrees that it is necessary, they will make all the necessary arrangements to repatriate **You** to **Your** appropriate destination, provided that **You** are medically fit to travel.

Important notes:

We will only pay for **Evacuation** costs that have been authorised and arranged by **Our Emergency** assistance service.

We will not pay for **Your Evacuation** costs if the **Evacuation** is directly or indirectly related to a **Medical Condition** which has been specifically excluded on **Your Certificate of Insurance**, or to any other **Medical Condition** or event specifically excluded in **Your Plan**.

3.4 Accessing elective Treatment in the USA

If **You** have selected the USA Elective **Treatment** option and need referral to a **Medical Practitioner** or **Hospital** in the USA, please follow the steps below.

If **You** are referred for **Out-Patient** diagnostics and surgery, **Day-Patient** or **In-Patient Treatment** in the USA, **You** must contact **Us** as soon as **You** can. **We** will confirm that the facility is an **In Network Medical Provider** and will try to arrange to settle the bill directly with the medical provider. If the medical provider **You** have selected is out of network, **We** will make arrangements to find an equivalent medical provider that is in network.

Step 1

Five working days before **Your Treatment** (or as early as possible), contact **Our** team of Clinical Advisers on
T +65 6880 2300 | F +65 6220 6950 | SingaporeService@now-health.com

A Clinical Adviser will verify **Your** entitlement to **Benefits** for the proposed **Treatment** and give **You** details on how to claim.

Tell **Us** the name of the medical facility, telephone number, fax number, contact name and the name of the **Medical Practitioner**.



Step 2

Choose how **You** would like to claim.

You can complete an online claim form at www.now-health.com. Claim forms are available within **Your** online secure portfolio area.

Alternatively, **You** can download a claim form to send to **Us** or use a printed claim form. **You** can request a form from **Our** customer service team, or **Your** intermediary, if **You** are using one.

Call **Us** on +65 6880 2300 to request a printed claim form, or if **You** would like help to access **Your** online secure portfolio area.

Complete all relevant sections of the claim form. Take the claim form with **You** and ask the medical provider to complete it and fax it to **Us**.



Step 3

When **You** arrive at the medical provider on the day of **Your Treatment**, show **Your** membership card and tell the medical provider that **We** have arranged **Direct Billing** through **Our** agents in the USA, AXA Assistance.

We may also ask **You** to fill in some extra forms, such as an agreement that the medical provider can release information about **You** to **Us**. **You** can access all forms from **Your** online secure portfolio area at www.now-health.com.

You will need to pay any **Excess** on **Your Plan** to the medical provider before **You** leave.



Step 4

When **You** leave, ask the medical provider to send the original claim form and bill to **Us** for payment. **You** can track all subsequent claims activity on **Your** online secure portfolio area. Log in at www.now-health.com using **Your** username and password.

Important notes:

Please contact **Us** before **You** receive any **In-Patient Treatment**, **Day-Patient Treatment** or major **Out-Patient Treatment**. If **You** don't contact **Us** before **Your** admission, **We** may not be able to arrange to pay the medical provider directly. This might mean that **You** have to pay a deposit to the **Hospital** or pay **Your** bill in full.

If **You** go to an **Out of Network Medical Provider**, **We** will apply a **Co-Insurance** of 50% to any **Eligible Treatment** as per **Your Benefit Schedule**. **You** will be responsible for the difference, which **You** will have to pay directly to the **Out of Network Medical Provider**.

We reserve the right to refuse to cover any medical expenses that **You** incur in the USA that **We** have not authorised.

If **We** pay the medical provider directly for any **Treatment** that is not **Eligible** under **Your Plan**, **You** must refund the equivalent sum to **Us**.

You will need to pay any **Excess** on **Your Plan** to the medical provider before **You** leave.

3.5 What must I provide when making a claim?

Please make sure that **You** complete all the forms **We** ask **You** to.

You must send **Us** all **Your** claim information within six months of the first day of **Treatment** (unless this is not reasonably possible).

If the total amount **You** are claiming now or have claimed (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500, please ensure Section 3 of the claim form is completed by the treating **Medical Practitioner**.

3.6 Do I need to provide any other information?

It may not always be possible to assess the eligibility of **Your** claim from the claim form alone, which means **We** may sometimes ask **You** for additional information. This will only ever be reasonable information that **We** need to assess **Your** claim.

We may request access to **Your** medical records including medical referral letters. If **You** don't reasonably allow **Us** access to this important information, **We** will have to refuse **Your** claim. This means that **We** will also recoup any previous payments that **We** have made for that **Medical Condition**.

There may be instances where **We** are uncertain about the eligibility of a claim. If this is the case, **We** may, at **Our** own cost, ask a **Medical Practitioner** chosen by **Us** to review the claim. They may review the medical facts relating to a claim or examine **You** in connection with the claim. In choosing a relevant **Medical Practitioner**, **We** will take into account **Your** personal circumstances. **You** must co-operate with any **Medical Practitioner** chosen by **Us** or **We** will not pay **Your** claim.

3.7 What should I do if I also have cover on another insurance policy?

If **You** are making a claim, **You** must tell **Us** if **You** are able to claim any costs from another insurance policy. If another insurance policy is involved, **We** will only pay **Our** proper share.

3.8 What should I do if the Benefits I am claiming relate to an injury or Medical Condition caused by another person?

You must tell **Us** on the claim form if **You** are able to claim any of the cost from another person.

If **You** are claiming for **Treatment** for a **Medical Condition** caused by another person, **We** will still pay for **Benefits** that **You** can claim under the **Plan**.

If **You** are claiming for **Treatment** for an injury caused by another person, **We** obtain the right by law, to recover the sum of the **Benefits** paid from the other person. **You** must tell **Us** as quickly as possible about any action against another person and keep **Us** informed of any outcome or settlement of this action.

Should **You** successfully recover any monies from the third party, they should be repaid directly to **Us** within 21 days of receipt on the following basis:

- if the claim against the third party settles in full, **You** must repay **Our** outlay in full; or
- if **You** recover only a percentage of **Your** claim for damages **You** must repay the same percentage of **Our** outlay to **Us**.

If **You** do not repay **Us** (including any interest recovered from the third party), **We** are entitled to recover the same from **You**. In addition, **Your Plan** may be cancelled in line with section 9 in the Rights and Responsibilities section.

The rights and remedies in this clause are in addition to and not instead of rights or remedies provided by law.

3.9 If You have an Excess and or Co-Insurance on Your Plan

Any **Excess** or **Co-Insurance** is shown on **Your Certificate of Insurance** and charged in the same currency as **Your** premium.

An **Excess** or **Co-Insurance** is the amount **You** pay towards the cost of a claim for any **Insured Person** on **Your Plan**. **You** can choose the type and level of **Excess** when **You** buy or renew **Your Plan**. When a claim is made, any **Excess** is automatically deducted.

The **Excess** applies per **Insured Person**, per **Medical Condition**, per **Period of Cover**. For example, if the **Insured Person** claims for **In-Patient Treatment** for two separate **Medical Conditions**, an **Excess** will apply to each **Medical Condition** rather than a single **Excess** relating to the **In-Patient Treatment**. An **Excess** will always be deducted before any **Co-Insurance** percentage is applied.

Even if **You** have selected **Out-Patient Direct Billing**, **You** will still be responsible for any **Co-Insurance** payments under the **Plan** and the **Plan Excess** will still apply to both **In-Patient** and **Day-Patient Treatment**.

A **Co-Insurance** is a percentage payment made by **You** per **Medical Condition** per **Period of Cover**. For example, if an **Insured Person** claims for **Out-Patient Treatment**, the **Excess** will be deducted first and the **Co-Insurance** will be calculated on the remaining amount.

You need to submit **Your** claim form and bills, even if the **Excess** is greater than the **Benefits You** are claiming, so **We** can administer **Your Plan** correctly. When **You** make a claim, **We** will reduce the amount **We** pay **You** until the **Excess** limit is used up.

3.10 How will claim reimbursements be calculated?

Claims reimbursements will in all cases be based on the date of **Treatment**, and in the first instance will be paid in the same currency as the claim invoice. Alternatively, the currency of the **Plan** may be requested or **We** will endeavour to pay in another currency of **Your** choice. **We** will convert currencies based on the exchange rates quoted by Citibank as of the **Treatment** date.

3.11 What currencies can claims be made in?

You have the choice of claims reimbursement in either the currency of **Your Plan**, the currency **You** incurred **Your** claim in, or another currency of **Your** choice. Listed below are the currencies **We** can transact in.

*Subject to currency local and/or international restrictions & regulations.

ALL Albanian Lek	KMF Comoros Franc	LVL Latvian Lats	WST Samoan Tala
DZD Algerian Dinar	CRC Costa Rican Colon	LSL Lesotho Loti	SAR Saudi Riyal
AMD Armenian Dram	HRK Croatian Kuna	LBP Lebanese Pound	RSB Serbian Dinar
AOA Angola Kwanza	CZK Czech Koruna	LYD Libyan Dinar	SCR Seychelles Rupee
AUD Australian Dollar	DKK Danish Krone	LTL Lithuanian Litas	SLL Sierra Leone Leone
AZN Azerbaijan Manat	DJF Djibouti Franc	MKD Macedonia Denar	SGD Singapore Dollar
BSD Bahamian Dollar	DOP Dominican Peso	MOP Macau Pataca	SBD Solomon Islands Dollar
BHD Bahraini Dinar	EGP Egyptian Pound	MGA Madagascar Ariary	ZAR South African Rand
BDT Bangladesh Taka	EUR EMU Euro	MWK Malawi Kwacha	SRD Suriname Dollar
BBD Barbados Dollar	ERN Eritrea Nakfa	MVR Maldives Rufiyaa	SEK Swedish Krona
BYR Belarus Ruble	EEK Estonian Kroon	MRO Mauritanian Ouguiya	SZL Swaziland Lilangeni
BZD Belize Dollar	ETB Ethiopia Birr	MUR Mauritius Rupee	CHF Swiss Franc
BMD Bermudian Dollar	FJD Fiji Dollar	MXN Mexican Peso	LKR Sri Lankan Rupee
BTN Bhutan Ngultrum	GMD Gambian Dalasi	MDL Moldavian Leu	TWD Taiwan New Dollar
BOB Bolivian Boliviano	GEL Georgian Lari	MNT Mongolian Tugrik	TZS Tanzanian Shilling
BAM Bosnia & Herzegovina	GHS Ghanaian Cedi	MAD Moroccan Dirham	THB Thai Baht
Convertible Mark	GTQ Guatemalan Quetzal	MZN Mozambique Metical	TOP Tongan Pa'anga
BWP Botswana Pula	GNF Guinea Republic Franc	NAD Namibian Dollar	TTD Trinidad and Tobago Dollar
BRL Brazilian Real	GYD Guyana Dollar	NPR Nepal Rupee	TND Tunisian Dinar
BND Brunei Dollar	HTG Haitian Gourde	NZD New Zealand Dollar	TRY Turkish Lira
BGN Bulgarian Lev	HNL Honduran Lempira	NIO Nicaraguan Cordoba	AED U.A.E. Dirham
BIF Burundi Franc	HKD Hong Kong Dollar	NGN Nigerian Naira	UGX Ugandan Shilling
CAD Canadian Dollar	HUF Hungarian Forint	NOK Norwegian Krone	GBP U.K. Pound Sterling
CVE Cape Verde Escudo	INR Indian Rupee	OMR Omani Rial	UAH Ukraine Hryvnia
KHR Cambodia Riel	IDR Indonesian Rupiah	PKR Pakistani Rupee	UYU Uruguayan Peso
KYD Cayman Island Dollar	ILS Israeli Shekel	PAP Papua New Guinea Kina	USD U.S. Dollar
XOF West African States	JMD Jamaican Dollar	PYG Paraguayan Guarani	UZS Uzbekistan Som
CFA Franc BCEAO	JPY Japanese Yen	PEN Peruvian Nuevo Sol	VUV Vanuatu Vatu
XAF Central African States	JOD Jordanian Dinar	PHP Philippine Peso	VEF Venezuelan Bolivar
CFA Franc BEAC	KZT Kazakhstan Tenge	PLN Polish Zloty	VND Vietnam Dong
XPF Central Pacific Franc	KES Kenyan Shilling	QAR Qatari Riyal	YER Yemeni Rial
CLP Chilean Peso	KRW Korean Won	RON Romanian Leu	ZMK Zambia Kwacha
CNY Chinese Yuan Renminbi	KWD Kuwaiti Dinar	RUB Russian Ruble	
COP Colombian Peso	LAK Laos Kip	RWF Rwandan Franc	

4. Health at Hand

24 hour medical support for you and your family

Through our telephone health information service, Health at Hand, you have access to a qualified and experienced team of healthcare professionals 24 hours a day, 365 days a year.

Whether you are calling because you have late night worries about a child's health, or you have some questions that you forgot to ask your GP, it's likely that Health at Hand will be able to provide you with the help you need.

The team of nurses, pharmacists, counsellors and midwives is on hand to give you the benefit of their expertise. They can answer your questions and give you all the latest information on specific illnesses, treatments and medications as well as details of local and national organisations. They can also send you free fact sheets and leaflets on a wide range of medical issues, conditions and treatments, and will happily phone you back afterwards to discuss any further questions you may have from what you have read.

Health at Hand – +65 6880 2305

Health at Hand is available to you anytime – day or night, 365 days a year.

Please remember to have your membership number to hand before you call.

Please note:

Health at Hand does not diagnose or prescribe and is not designed to take the place of your GP. However, it can provide you with valuable information to help put your mind at rest. As Health at Hand is a confidential service, any information you discuss is not shared with our Customer Service team. If you wish to authorise treatment, enquire about a claim or have a membership query, our Customer Service team will be happy to help you.

Product Information

5. Benefits: What is covered?

All the **Benefits** covered by WorldCare are shown in the **Benefit Schedule** in this section. The **Benefit** limits are per **Insured Person** and either per **Medical Condition** or per **Period of Cover**, with lifetime limits in place for **Terminal** illness.

Please remember that this **Plan** is not intended to cover all eventualities.

In return for payment of the premium, **We** agree to provide cover as set out in the terms of this **Plan**.

Please refer to the definition of **Plan** in section 1 for details of the documents that make up **Your Plan**.

5.1 Summary of WorldCare

WorldCare has been designed to provide cover for **Reasonable and Customary Charges** for **Medically Necessary** and active **Treatment** of disease, illness or injury.

WorldCare provides worldwide cover, excluding the USA, unless the USA elective **Treatment** option is selected.

A summary of each **Plan** is shown below:

Essential	Cover for In-Patient and Day-Patient Treatment , and the option for a higher Excess to lower Your premiums, if You want to cover high cost/low frequency major medical events only.
Advance	As with Essential , and limited cover for Out-Patient Treatment .

Optional Benefits

To provide extra flexibility, **You** can also select additional optional **Benefits** that might be important to **You**.

Cover options available are:

USA Elective Treatment	Costs associated with Eligible In-Patient, Day-Patient and Out-Patient Treatment in the USA will be paid in full where Treatment is received in Our Network of Providers.
Co-Insurance Out-Patient Charges	With a 20% Co-Insurance in addition to the Plan Excess per Medical Condition on Advance Plan option.
Your choice of Plan Excess	A standard Excess applies per Insured Person per Medical Condition per Period of Cover , but if You prefer to reduce Your premium You can select a higher Excess .
Out-Patient Charges (Essential only)	Add Out-Patient Benefits inclusive of Maintenance of Chronic Medical Conditions within the Benefit sub-limit to the Essential Plan .
Routine and Restorative Dental	Add dental Benefits to the Advance Plan option.
Routine Maternity	Add Maternity Benefits to the Advance Plan . Only available when the dental option has been selected.

Please note:

If a nil **Excess** option is selected on **Advance Plan** option, the **Insured Person** will **Benefit** from **Out-Patient Direct Billing** within **Our Out-Patient Direct Billing** Provider Network for **Out-Patient** charges. If **Your** membership card has “**Out-Patient Direct Billing**” clearly marked, the medical facility will not ask **You** to settle the charges. They will do this directly with **Us**.

The above is a summary of just some of the **Plan Benefits**. For full details of the **Benefits** and exclusions, it is important that **You** read this handbook in full. For the full **Benefit Schedule**, please go to section 5.3.

5.2 Pre-Authorisation

When **You** should contact **Us** before **Treatment** starts.

Your Plan with **Us** will only cover **Reasonable and Customary Charges** for **Treatment** that is **Medically Necessary**. It is important that **You** contact **Us** before **Treatment** for **Us** to confirm if such **Treatment** is **Eligible** under **Your Plan**.

Pre-Authorisation is therefore required before undertaking **Treatment** and incurring charges.

The **Benefit Schedule** details those **Benefits** requiring **Pre-Authorisation** by showing “**Pre-Authorisation** ☎”.

You should contact **Our** team of Clinical Advisers on +65 6880 2300 | Fax +65 6220 6950.

Pre-Authorisation means all costs under this **Benefit** require **Pre-Authorisation** from **Us**, which may or may not be included in **Your Plan**.

Pre-Authorisation is required for the following:

- All **In-Patient Treatment**
- All pre-planned **Day-Patient Treatment**
- All pre-planned surgery
- **Diagnostic Procedures** – positron emission tomography (PET) scans
- **In-Patient Psychiatric Treatment**
- **Evacuation and Repatriation**
- Mortal Remains
- Physiotherapy for the **Plan** option after every 10 sessions
- Nursing Care at home
- AIDS
- USA elective **Treatment**

If **Pre-Authorisation** is not obtained and **Treatment** is received and is subsequently proven not to be **Medically Necessary**, **We** reserve the right to decline **Your** claim. If **Treatment** is **Medically Necessary**, but **You** did not obtain **Pre-Authorisation**, **We** will pay only 80% of the **Eligible Benefits**.

In the case of any **Emergency**, **You**, the treating **Medical Practitioner** or the **Hospital**, must contact **Our** 24 hour **Emergency** assistance service as soon as possible. Failure to obtain **Pre-Authorisation** for **Treatment** of an **Eligible Medical Condition** means **You** may incur a proportion of the costs.

5.3 Now Health International: WorldCare

WorldCare has been designed to provide cover for **Reasonable and Customary Charges** for **Medically Necessary** and active **Treatment** of disease, illness or injury. The **Benefit Schedule** below details the cover provided by each **Plan**. This is additional information that should be read in conjunction with this complete handbook.















Benefits aim to cover short term **Treatment** of acute episodes of **Chronic Conditions**, to return **You** to the state of health **You** were in immediately before suffering the episode, or which leads to a full recovery. If this is not possible and maintenance therapy of a **Chronic Condition**, such as but not limited to asthma, diabetes, and hypertension, is required, such cover will be provided by **Benefit 1: Chronic Conditions**, and the **Plan** limit per **Insured Person**, per **Period of Cover** will apply. If **You** are unsure of **Your** particular circumstances, please contact **Our** Customer Service team before incurring any **Treatment** costs.











Some cover states “Full Refund” and this means that **Eligible** claims are covered up to the annual maximum **Plan** limit, after any deduction of any **Excess** or **Co-Insurance** or similar condition, if **Reasonable and Customary Charges** for **Medically Necessary Treatment** are incurred.



5.3.1 WorldCare Essential

Benefit	Essential
Annual Maximum Plan Limit 24/7 helpline and assistance services available on all Plans	USD 3m
1. Maintenance of Chronic Medical Conditions: <i>Maintenance of chronic Medical Conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, examinations, check-ups, Drugs and Dressings and/or tests up to the Benefit limits following Your Entry Date. This Benefit does not cover renal failure and dialysis. Claims for this will fall under Benefit 6. Claims for Cancer will fall under Benefit 8.</i>	 Not covered
2. Hospital Charges, Medical Practitioner and Specialist Fees: <i>i) Charges for In-Patient or Day-Patient Treatment made by a Hospital including charges for accommodation (ward/semi-private or private); Diagnostic Tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a Qualified Nurse; Drugs and Dressings prescribed by a Medical Practitioner or Specialist; and surgical appliances used by the Medical Practitioner during surgery. This includes pre and post-operative consultations while an In-Patient or Day-Patient and includes charges for intensive care.</i> <i>ii) Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an Eligible Medical Condition which required In-Patient or Day-Patient Hospital Treatment.</i>	<i>(i)</i>  Full refund Pre-Authorisation for (i) 📞 <i>(ii)</i>  Up to USD 1,500 per Medical Condition
3. Diagnostic Procedures: <i>Medically Necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans.</i>	Pre-Authorisation for PET 📞  Full refund for In-Patient pre and post-operative scans
4. Emergency Ambulance Transportation: <i>Emergency road ambulance transport costs to or between Hospitals, or when considered Medically Necessary by a Medical Practitioner or Specialist.</i>	 Full refund
5. Parent Accommodation: <i>The cost of one parent staying in Hospital overnight with an Insured Person under 18 years old while the child is admitted as an In-Patient for Eligible Treatment.</i>	 Full refund
6. Renal Failure and Renal Dialysis: <i>i) Treatment of renal failure, including renal dialysis on an In-Patient basis.</i> <i>ii) Treatment of renal failure, including renal dialysis on a Day-Patient or Out-Patient basis.</i>	 <i>(i)</i> Up to six weeks full refund for In-Patient pre and post-operative care  <i>(ii)</i> Not covered
7. Organ Transplant: <i>i) Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the Insured Person as a recipient.</i> <i>In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Benefit 12 but excluded from Benefit 7 – Organ Transplant.</i> <i>ii) Medical costs associated with the donor as an In-Patient or Day-Patient, with the exception of the cost of the donor organ search.</i> <i>We only pay for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.</i>	<i>(i)</i>  Full refund <i>(ii)</i>  Up to USD 50,000 per Period of Cover
8. Cancer Treatment: <i>Treatment given for Cancer received as an In-Patient, Day-Patient or Out-Patient. Includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis.</i>	 Full refund

Benefit	Essential
<p>9. Pregnancy and Childbirth Medical Conditions:</p> <p><i>In-Patient Treatment</i> of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. As an illustration, We would consider Treatment of the following:</p> <ul style="list-style-type: none"> ectopic Pregnancy (where the foetus is growing outside the womb) hydatidiform mole (abnormal cell growth in the womb) retained placenta (afterbirth retained in the womb) placenta praevia eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia) diabetes (If You have exclusions because of Your past medical history which relate to diabetes, then You will not be covered for any Treatment for diabetes during Pregnancy) post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth) miscarriage requiring immediate surgical Treatment failure to progress in labour 	<p>Full refund</p>
<p>10. New Born Cover:</p> <p><i>In-Patient Treatment</i> of premature birth (i.e. prior to age 37 weeks gestation) or an Acute Condition being suffered by a New Born baby of an Insured Person which manifests itself within 30 days following birth. Provided that the New Born baby is added to the Plan within 30 days of birth and premium paid. Cover for multiple births will be covered up to the same limits shown.</p>	<p>Up to USD 100,000 per Period of Cover</p>
<p>11. Hospital Accommodation for New Born Accompanying their Mother:</p> <p><i>Hospital Accommodation</i> costs relating to a New Born baby (up to 16 weeks old) to accompany its mother (being an Insured Person) while she is receiving Eligible Treatment as an In-Patient in a Hospital.</p>	<p>Full refund</p>
<p>12. Congenital Disorder:</p> <p><i>In-Patient Treatment</i> for a Congenital Disorder. In circumstances where a Congenital Disorder manifests itself in a New Born baby within 30 days of birth, cover for such Medical Conditions will be provided under Benefit 10 but excluded from Benefit 12 – Congenital Disorders.</p>	<p>Up to USD 100,000 per Period of Cover</p>
<p>13. Reconstructive Surgery:</p> <p>Reconstructive surgery required to restore natural function or appearance following an Accident or following a Surgical Procedure for an Eligible Medical Condition, which occurred after an Insured Person's Entry Date or Start Date whichever is later.</p>	<p>Full refund</p>
<p>14. Rehabilitation:</p> <p>On the advice of a Specialist as an integral part of Treatment for a Medical Condition necessitating admission to a recognised Rehabilitation unit of a Hospital. Where the Insured Person was confined to a Hospital as an In-Patient for at least three consecutive days, and where a Specialist confirms in writing that Rehabilitation is required. Admission to a Rehabilitation unit must be made within 14 days of discharge from Hospital. Such Treatment should be under the direct supervision and control of a Specialist and would cover:</p> <ol style="list-style-type: none"> Use of special Treatment rooms Physical therapy fees Speech therapy fees Occupational therapy fees 	<p>Full refund for Eligible In-Patient Treatment only up to 30 days per Medical Condition</p>
<p>15. In-Patient Emergency Dental Treatment:</p> <p>This means Emergency restorative dental Treatment required to sound, natural teeth following an Accident which necessitates Your admission to Hospital for at least one night.</p> <p>The dental Treatment must be received within 10 days of the Accident. This Benefit covers all costs incurred for Treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply:</p> <ul style="list-style-type: none"> If the Treatment involves replacing a crown, bridge facing, veneer or denture, We will pay only the reasonable and customary cost of a replacement of similar type or quality If implants are clinically needed We will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead Damage to dentures providing they were being worn at the time of the injury 	<p>Full refund</p>
<p>16. In-Patient Psychiatric Treatment:</p> <p><i>In-Patient Treatment</i> in a recognised Psychiatric unit of a Hospital. All Treatment must be administered under the direct control of a Registered Psychiatrist.</p>	<p>Pre-Authorisation ☒</p> <p>Full Refund limited to 30 days per Period of Cover</p>











Benefit	Essential
<p>17. Terminal Illness:</p> <p><i>Palliative and Hospice Care: On diagnosis of a Terminal illness, costs for any In-Patient, Day-Patient or Out-Patient Treatment given on the advice of a Medical Practitioner or Specialist for the purpose of offering temporary relief of symptoms. Charges for Hospital or hospice accommodation, nursing care by a Qualified Nurse and prescribed Drugs and Dressings are covered.</i></p>	<p> Eligible In-Patient and Day-Patient Treatment only up to USD 50,000 lifetime limit</p>
<p>18. Emergency Non-Elective Treatment USA Cover:</p> <p><i>For planned trips up to 30 days of duration. Treatment by a Medical Practitioner or Specialist starting within 24 hours of the Emergency event, required as a result of an Accident or the sudden beginning of a severe illness resulting in a Medical Condition that presents an immediate threat to the Insured Person's health.</i></p> <p><i>Charges relating to routine Pregnancy and childbirth are specifically excluded from this Benefit.</i></p>	<p> Full Refund for Accident requiring In-Patient and Day-Patient care</p> <p> Illness: In-Patient and Day-Patient care Up to USD 25,000 per Period of Cover</p>
<p>19. Evacuation and Repatriation:</p> <p>Evacuation</p> <p><i>Arrangements will be made to move an Insured Person who has a critical, life-threatening Eligible Medical Condition to the nearest medical facility for the purpose of admission to Hospital as an In-Patient or Day-Patient.</i></p> <p><i>Reasonable expenses for:</i></p> <ul style="list-style-type: none"> i) <i>Transportation costs of an Insured Person in the event of Emergency Treatment and Medically Necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying person who has travelled as an escort.</i> ii) <i>Reasonable local travel costs to and from medical appointments when Treatment is being received as a Day-Patient.</i> iii) <i>Reasonable travel costs for a locally-accompanying person to travel to and from the Hospital to visit the Insured Person following admission as an In-Patient.</i> iv) <i>Reasonable costs for non-Hospital Accommodation only for immediate pre and post-Hospital admission periods provided that the Insured Person is under the care of a Specialist.</i> <p><i>Excesses do not apply to transportation costs incurred under this Benefit.</i></p> <p><i>Costs of Evacuation do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts.</i></p> <p><i>Our medical advisers will decide the most appropriate method of transportation for the Evacuation and this Benefit will not cover travel if it is against the advice of Our medical advisers or where the medical facility does not have appropriate facilities to treat the Eligible Medical Condition.</i></p> <p>Repatriation</p> <p><i>An economy class airfare ticket to return the Insured Person and a locally-accompanying person who has travelled as an escort to the site of Treatment or the Insured Person's principal Country of Nationality or principal Country of Residence, as long as the journey is made within one month of completion of Treatment.</i></p> <p><i>This Benefit specifically excludes routine Pregnancy and childbirth costs, except for Benefit 9 – Pregnancy and childbirth Medical Conditions.</i></p>	<p>Pre-Authorisation </p> <ul style="list-style-type: none"> i)  Full refund ii)  Full refund iii)  Full refund iv)  Up to USD 200 per day Up to USD 7,500 per person, per Evacuation <p>Pre-Authorisation </p> <p> Full refund</p>
<p>20. Mortal Remains:</p> <p><i>In the event of death from an Eligible Medical Condition, Reasonable and Customary Charges for:</i></p> <ul style="list-style-type: none"> i) <i>Costs of transportation of body or ashes of an Insured Person to his/her Country of Nationality or Country of Residence, or</i> ii) <i>Burial or cremation costs at the place of death in accordance with reasonable and customary practice.</i> 	<p>Pre-Authorisation </p> <ul style="list-style-type: none"> i)  Full refund ii)  Up to USD 10,000
<p>21. Hospital Cash Benefit:</p> <p><i>This Benefit is payable for each night an Insured Person receives In-Patient Treatment and only if an Insured Person is admitted for In-Patient Treatment before midnight, and the Treatment is received free of charge that would have otherwise been Eligible for Benefit privately under this Plan. Cover under this Benefit is limited to a maximum of 30 nights per Period of Cover.</i></p> <p><i>For this Benefit exclusion 6.12 does not apply.</i></p>	<p> USD 125 per night</p>

Benefit	Essential
<p>22. Out-Patient Charges :</p> <p>i) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings.</p> <p>ii) Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist.</p>	<p>(i)  Pre-operative consultation and Diagnostic Procedures within 15 days from the admission and post hospitalisation up to max USD 2,000 or 30 days per Medical condition per Period of cover</p> <p>(ii)  Not covered</p>
<p>23. Day-Patient or Out-Patient Surgery:</p> <p>Treatment costs for a Surgical Procedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any pre or post-operative consultations are payable under Benefit 22 – Out-Patient charges.</p>	<p> Full refund</p>
<p>24. Out Patient Psychiatric Illness:</p> <p>Out-Patient Treatment administered under the direct control of a Registered Psychiatrist when referred by a Medical Practitioner or Specialist.</p>	<p> Not covered</p>
<p>25. Alternative Therapies:</p> <p>i) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment.</p> <p>ii) Treatment or therapies administered by a recognised Traditional Chinese Medicine Practitioner.</p> <p>We do not cover charges for general chiropody or podiatry. For this Benefit exclusion 6.12 does not apply.</p>	<p> Not covered</p>
<p>26. Nursing Care at Home:</p> <p>i) Care given by Qualified Nurse in the Insured Person's own home, which is immediately received subsequent to Treatment as an In-Patient or Day-Patient on the recommendation of a Medical Practitioner or Specialist.</p> <p>ii) Emergency Medical Practitioner (GP) home visits out of normal clinic hours.</p>	<p>(i)  Not covered Pre-Authorisation for (i) </p> <p>(ii)  Not covered</p>
<p>27. AIDS:</p> <p>Medical expenses, which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. As result of proven occupation Accident * or blood transfusion **. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, Drugs and Dressings (except experimental or those unproven), Hospital Accommodation and nursing fees.</p> <p>* For members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation; and they contracted the HIV infection three years after the Entry Date or Start Date, whichever is later; and the incident from which they contracted the HIV infection was reported, investigated and documented according to normal procedures for the Insured Person's occupation; and a test showing no HIV or antibodies to such a virus was made within five days of the incident; and a positive HIV test occurred within 12 months of the reported occupational Accident.</p> <p>** As long as the blood transfusion was received as an In-Patient as part of Medically Necessary Treatment.</p> <p>Waiting Period: Cover only available after three years of continuous membership.</p>	<p>Pre-Authorisation </p> <p> Eligible In-Patient and Day-Patient Treatment only up to USD 25,000 per Period of Cover</p>

Options to Core Benefits	Essential
28. Out-Patient Charges <ul style="list-style-type: none"> i) Medical Practitioner fees including consultation, Specialist fees, Diagnostic Tests and cost associated with Maintenance of chronic Medical Conditions, prescribed Drugs and Dressings. ii) Physiotherapy by a registered Physiotherapist, when referred by a Medical Practitioner, or Specialist. 	 <p>Optional</p> <p>i) Up to USD 4,500 per Period of Cover</p> <p>ii) Full refund up to a maximum 10 sessions per Period of Cover</p>
29. USA Elective Treatment: <ul style="list-style-type: none"> i) Costs associated with Eligible In-Patient Treatment and Day-Patient Treatment in the USA will be paid in full where Treatment is received in the Now Health International Provider Network. ii) Costs associated with Eligible Out-Patient Treatment in the USA will be paid in full where Treatment is received in the Now Health International Provider Network. <p>Treatment that is not received in the Now Health International Provider Network will be subject to a 50% Co-Insurance.</p>	<p>Pre-Authorisation for Out-Patient diagnostics and surgery, Day-Patient and In-Patient Treatment 📞</p>  <p>Optional</p> <p>Up to USD 1.5m per Insured Person per Period of Cover</p>

Excess Options	Essential
Standard Excess	Nil
Optional Excess Please note: Excesses do not apply to transportation costs incurred under Benefit 19 , but would apply to any Medically Necessary Treatment required under Benefit 19 .	USD 1,000 USD 5,000





5.3.2 WorldCare Advance

Benefit	Advance
Annual Maximum Plan Limit 24/7 helpline and assistance services available on all Plans	USD 3m
1. Maintenance of Chronic Medical Conditions: <i>Maintenance of chronic Medical Conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, examinations, check-ups, Drugs and Dressings and/or tests up to the Benefit limits following Your Entry Date. This Benefit does not cover renal failure and dialysis. Claims for this will fall under Benefit 6. Claims for Cancer will fall under Benefit 8.</i>	 Up to USD 15,000 per Period of Cover
2. Hospital Charges, Medical Practitioner and Specialist Fees: <i>i) Charges for In-Patient or Day-Patient Treatment made by a Hospital including charges for accommodation (ward/semi-private or private); Diagnostic Tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a Qualified Nurse; Drugs and Dressings prescribed by a Medical Practitioner or Specialist; and surgical appliances used by the Medical Practitioner during surgery. This includes pre and post-operative consultations while an In-Patient or Day-Patient and includes charges for intensive care.</i> <i>ii) Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an Eligible Medical Condition which required In-Patient or Day-Patient Hospital Treatment.</i>	<i>(i)</i>  Full refund Pre-Authorisation for (i)  <i>(ii)</i>  Up to USD 1,500 per Medical Condition
3. Diagnostic Procedures: <i>Medically Necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans.</i>	Pre-Authorisation for PET   Full refund
4. Emergency Ambulance Transportation: <i>Emergency road ambulance transport costs to or between Hospitals, or when considered Medically Necessary by a Medical Practitioner or Specialist.</i>	 Full refund
5. Parent Accommodation: <i>The cost of one parent staying in Hospital overnight with an Insured Person under 18 years old while the child is admitted as an In-Patient for Eligible Treatment</i>	 Full refund
6. Renal Failure and Renal Dialysis: <i>i) Treatment of renal failure, including renal dialysis on an In-Patient basis.</i> <i>ii) Treatment of renal failure, including renal dialysis on a Day-Patient or Out-Patient basis.</i>	<i>(i)</i>  Up to six weeks full refund <i>(ii)</i>  Up to USD 75,000 per Period of Cover
7. Organ Transplant: <i>i) Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the Insured Person as a recipient.</i> <i>In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Benefit 12 but excluded from Benefit 7 – Organ Transplant.</i> <i>ii) Medical costs associated with the donor as an In-Patient or Day-Patient, with the exception of the cost of the donor organ search.</i> <i>We only pay for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.</i>	<i>(i)</i>  Full refund <i>(ii)</i>  Up to USD 50,000 per Period of Cover
8. Cancer Treatment: <i>Treatment given for Cancer received as an In-Patient, Day-Patient or Out-Patient. Includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis.</i>	 Full refund

Benefit	Advance
<p>9. Pregnancy and Childbirth Medical Conditions:</p> <p><i>In-Patient Treatment</i> of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy, or an Eligible Medical Condition which arises during childbirth. As an illustration We would consider Treatment of the following:</p> <ul style="list-style-type: none"> • Ectopic Pregnancy (where the foetus is growing outside the womb) • Hydatidiform mole (abnormal cell growth in the womb) • Retained placenta (afterbirth retained in the womb) • Placenta praevia • Eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia) • Diabetes (If You have exclusions because of Your past medical history which relate to diabetes, then You will not be covered for any Treatment for diabetes during Pregnancy) • Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth) • Miscarriage requiring immediate surgical Treatment • Failure to progress in labour 	 Full refund
<p>10. New Born Cover:</p> <p><i>In-Patient Treatment</i> of premature birth (i.e. prior to age 37 weeks gestation) or an Acute Condition being suffered by a New Born baby of an Insured Person which manifests itself within 30 days following birth. Provided that the New Born baby is added to the Plan within 30 days of birth and premium paid. Cover for multiple births will be covered up to the same limits shown.</p>	 Up to USD 100,000 per Period of Cover
<p>11. Hospital Accommodation for New Born Accompanying their Mother:</p> <p><i>Hospital Accommodation</i> costs relating to a New Born baby (up to 16 weeks old) to accompany its mother (being an Insured Person) while she is receiving Eligible Treatment as an In-Patient in a Hospital.</p>	 Full refund
<p>12. Congenital Disorder:</p> <p><i>In-Patient Treatment</i> for a Congenital Disorder. In circumstances where a Congenital Disorder manifests itself in a New Born baby within 30 days of birth, cover for such Medical Conditions will be provided under Benefit 10 but excluded from Benefit 12 – Congenital Disorders.</p>	 Up to USD 100,000 per Period of Cover
<p>13. Reconstructive Surgery:</p> <p>Reconstructive surgery required to restore natural function or appearance following an Accident or following a Surgical Procedure for an Eligible Medical Condition, which occurred after an Insured Person's Entry Date or Start Date whichever is later.</p>	 Full refund
<p>14. Rehabilitation:</p> <p>On the advice of a Specialist as an integral part of Treatment for a Medical Condition necessitating admission to a recognised Rehabilitation unit of a Hospital. Where the Insured Person was confined to a Hospital as an In-Patient for at least three consecutive days, and where a Specialist confirms in writing that Rehabilitation is required. Admission to a Rehabilitation unit must be made within 14 days of discharge from Hospital. Such Treatment should be under the direct supervision and control of a Specialist and would cover:</p> <ul style="list-style-type: none"> i) Use of special Treatment rooms ii) Physical therapy fees iii) Speech therapy fees iv) Occupational therapy fees 	 Full Refund up to 180 days per Medical Condition
<p>15. In-Patient Emergency Dental Treatment:</p> <p>This means Emergency restorative dental Treatment required to sound, natural teeth following an Accident which necessitates Your admission to Hospital for at least one night.</p> <p>The dental Treatment must be received within 10 days of the Accident. This Benefit covers all costs incurred for Treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply:</p> <ul style="list-style-type: none"> • If the Treatment involves replacing a crown, bridge facing, veneer or denture, We will pay only the reasonable and customary cost of a replacement of similar type or quality • If implants are clinically needed We will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead • Damage to dentures providing they were being worn at the time of the injury 	 Full refund
<p>16. In-Patient Psychiatric Treatment:</p> <p><i>In-Patient Treatment</i> in a recognised Psychiatric unit of a Hospital. All Treatment must be administered under the direct control of a Registered Psychiatrist.</p>	Pre-Authorisation   Full Refund limited to 30 days per Period of Cover

Benefit	Advance
<p>17. Terminal Illness:</p> <p><i>Palliative and Hospice Care:</i> On diagnosis of a Terminal illness, costs for any In-Patient, Day-Patient or Out-Patient Treatment given on the advice of a Medical Practitioner or Specialist for the purpose of offering temporary relief of symptoms. Charges for Hospital or hospice accommodation, nursing care by a Qualified Nurse and prescribed Drugs and Dressings are covered.</p>	<p>▶ Up to USD 50,000 lifetime limit</p>
<p>18. Emergency Non-Elective Treatment USA Cover:</p> <p><i>For planned trips up to 30 days of duration. Treatment by a Medical Practitioner or Specialist starting within 24 hours of the Emergency event, required as a result of an Accident or the sudden beginning of a severe illness resulting in a Medical Condition that presents an immediate threat to the Insured Person's health.</i></p> <p><i>Charges relating to routine Pregnancy and childbirth are specifically excluded from this Benefit.</i></p>	<p>▶ Full refund for Accident</p> <p>▶ Illness: up to USD 25,000 per Period of Cover</p>
<p>19. Evacuation and Repatriation:</p> <p>Evacuation</p> <p><i>Arrangements will be made to move an Insured Person who has a critical, life-threatening Eligible Medical Condition to the nearest medical facility for the purpose of admission to Hospital as an In-Patient or Day-Patient.</i></p> <p><i>Reasonable expenses for:</i></p> <ul style="list-style-type: none"> i) <i>Transportation costs of an Insured Person in the event of Emergency Treatment and Medically Necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying person who has travelled as an escort.</i> ii) <i>Reasonable local travel costs to and from medical appointments when Treatment is being received as a Day-Patient.</i> iii) <i>Reasonable travel costs for a locally-accompanying person to travel to and from the Hospital to visit the Insured Person following admission as an In-Patient.</i> iv) <i>Reasonable costs for non-Hospital Accommodation only for immediate pre and post-Hospital admission periods provided that the Insured Person is under the care of a Specialist.</i> <p><i>Excesses do not apply to transportation costs incurred under this Benefit.</i></p> <p><i>Costs of Evacuation do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts.</i></p> <p><i>Our medical advisers will decide the most appropriate method of transportation for the Evacuation and this Benefit will not cover travel if it is against the advice of Our medical advisers or where the medical facility does not have appropriate facilities to treat the Eligible Medical Condition.</i></p> <p>Repatriation</p> <p><i>An economy class airfare ticket to return the Insured Person and a locally-accompanying person who has travelled as an escort to the site of Treatment or the Insured Person's principal Country of Nationality or principal Country of Residence, as long as the journey is made within one month of completion of Treatment.</i></p> <p><i>This Benefit specifically excludes routine Pregnancy and childbirth costs, except for Benefit 9 – Pregnancy and childbirth Medical Conditions.</i></p>	<p>Pre-Authorisation 📞</p> <ul style="list-style-type: none"> (i) ▶ Full refund (ii) ▶ Full refund (iii) ▶ Full refund (iv) ▶ Up to USD 200 per day Up to USD 7,500 per person, per Evacuation <p>Pre-Authorisation 📞</p> <p>▶ Full refund</p>
<p>20. Mortal Remains:</p> <p><i>In the event of death from an Eligible Medical Condition, Reasonable and Customary Charges for:</i></p> <ul style="list-style-type: none"> i) <i>Costs of transportation of body or ashes of an Insured Person to his/her Country of Nationality or Country of Residence or,</i> ii) <i>Burial or cremation costs at the place of death in accordance with reasonable and customary practice.</i> 	<p>Pre-Authorisation 📞</p> <ul style="list-style-type: none"> (i) ▶ Full refund (ii) ▶ Up to USD 10,000
<p>21. Hospital Cash Benefit:</p> <p><i>This Benefit is payable for each night an Insured Person receives In-Patient Treatment and only if an Insured Person is admitted for In-Patient Treatment before midnight, and the Treatment is received free of charge that would have otherwise been Eligible for Benefit privately under this Plan. Cover under this Benefit is limited to a maximum of 30 nights per Period of Cover.</i></p> <p><i>For this Benefit exclusion 6.12 does not apply.</i></p>	<p>▶ USD 175 per night</p>

Benefit	Advance
22. Out-Patient Charges: <ul style="list-style-type: none"> i) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; prescribed Drugs and Dressings. ii) Physiotherapy by a Registered Physiotherapist, when referred by a Medical Practitioner, or Specialist. 	<ul style="list-style-type: none"> (i)  Full refund (ii)  Full refund up to a maximum of 30 sessions per Period of Cover Pre-Authorisation after every 10 sessions for (ii) 📞
23. Day-Patient or Out-Patient Surgery: <p><i>Treatment costs for a Surgical Procedure performed in a surgery, Hospital, day-care facility or Out-Patient department. Any pre or post-operative consultations are payable under Benefit 22 – Out-Patient charges.</i></p>	 Full refund
24. Out-Patient Psychiatric Illness: <p><i>Out-Patient Treatment administered under the direct control of a Registered Psychiatrist when referred by a Medical Practitioner or Specialist.</i></p>	 Up to USD 2,500 per Period of Cover
25. Alternative Therapies: <ul style="list-style-type: none"> i) Complementary medicine and Treatment by a therapist, when referred by a Medical Practitioner or Specialist. This Benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture Treatment. ii) Treatment or therapies administered by a recognised Traditional Chinese Medicine Practitioner. <p><i>We do not cover charges for general chiropody or podiatry. For this Benefit exclusion 6.12 does not apply.</i></p>	 Full refund up to a maximum of 30 visits per Period of Cover Pre-Authorisation for (i) and (ii) after every 10 visits 📞
26. Nursing Care at Home: <ul style="list-style-type: none"> i) Care given by Qualified Nurse in the Insured Person's own home, which is immediately received subsequent to Treatment as an In-Patient or Day-Patient on the recommendation of a Medical Practitioner or Specialist. ii) Medical Practitioner (GP) home visits for an Emergency GP home call-out during out of normal clinic hours. 	<ul style="list-style-type: none"> (i)  Full refund up to 45 days per Medical Condition Pre-Authorisation for (i) 📞 (ii)  Not covered
27. AIDS: <p><i>Medical expenses, which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. As result of proven occupation Accident* or blood transfusion**. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, Drugs and Dressings (except experimental or those unproven), Hospital Accommodation and nursing fees.</i></p> <p>* For members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation; and they contracted the HIV infection three years after the Entry Date or Start Date, whichever is later; and the incident from which they contracted the HIV infection was reported, investigated and documented according to normal procedures for the Insured Persons occupation; and a test showing no HIV or antibodies to such a virus was made within five days of the incident; and a positive HIV test occurred within 12 months of the reported occupational Accident.</p> <p>** As long as the blood transfusion was received as an In-Patient as part of Medically Necessary Treatment.</p> <p>Waiting Period: Cover only available after three years of continuous membership.</p>	<p>Pre-Authorisation 📞</p>  Up to USD 25,000 per Period of Cover

Options to Core Benefits	Advance
<p>28. Co-Insurance Out-Patient Charges: <i>As described in Benefit 22, but with a 20% Co-Insurance in addition to the Plan Excess per Medical Condition.</i></p>	 Optional
<p>29. Dental Care:</p> <p>i) Routine dental Treatment: Fees of a registered Dental Practitioner carrying out routine dental Treatment in a dental surgery. Routine dental Treatment means:</p> <ul style="list-style-type: none"> — Screening (twice per year), i.e. the assessment of diseased, missing and filled teeth, including X-rays where necessary, — Preventive scaling, polishing, and sealing (once per year), — Fillings (standard amalgam or composite fillings) and extractions, and — Root-canal Treatment (but not the fitting of a crown following root-canal Treatment). <p>No other Treatment is covered under the routine dental Treatment benefit. Waiting Period: Costs incurred within nine months from the Start Date are excluded. A Co-Insurance of 20% applies. For this Benefit exclusion 6.12 does not apply.</p> <p>ii) Complex Dental Treatment: Fees of a registered Dental Practitioner and associated costs for the following procedures: Eligible complex dental Treatment: including for example, Apicoectomy done to treat the following – Fractured tooth root; A severely curved tooth root; Teeth with caps or posts; Cyst or infection which is untreatable with root canal therapy; Root perforations; New or repair of crowns, dentures, inlays and bridges. Recurrent pain and infection; Persistent symptoms that do not indicate problems from X-rays. Calcification; Damaged root surfaces and surrounding bone requiring surgery.</p> <p>No other Treatment is covered by this Benefit. Waiting Period: Costs incurred within nine months from the Start Date are excluded. A Co-Insurance of 20% applies. A 50% Co-Insurance applies in respect of all orthodontic Treatment. For this Benefit, exclusion 6.12 does not apply.</p>	 Optional i) Up to USD 500 per Period of Cover ii) Up to USD 1,000 per Period of Cover
<p>30. Maternity (20% Co-Insurance): Medically Necessary costs incurred during normal Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or caesarean section. Well-baby examinations. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery.</p> <p>Waiting Period: Costs incurred within 12 months from the Start Date are excluded. A Co-Insurance of 20% applies. Please note, We do not pay for parenting or other teaching classes as these are a matter of personal choice. For this Benefit exclusion 6.23 does not apply.</p>	 Optional Up to USD 7,000 with a 20% co-insurance
<p>31. USA Elective Treatment:</p> <p>i) Costs associated with Eligible In-Patient and Day-Patient Treatment in the USA will be paid in full where Treatment is received in a Hospital listed in the Now Health International Provider Network.</p> <p>ii) Costs associated with Eligible Out-Patient Treatment in the USA will be paid in full where Treatment is received in the Now Health International Provider Network.</p> <p>Treatment that is not received in the Now Health International Provider Network will be subject to a 50% Co-Insurance.</p>	<p>Pre-Authorisation for Out-Patient diagnostics and surgery, Day-Patient and In-Patient Treatment</p>  Optional Up to USD 1.5m per Insured Person per Period of Cover

Excess Options	Advance
Standard Excess	Nil
<p>Optional Excess: Please note: Excesses do not apply to transportation costs incurred under Benefit 19, but would apply to any Medically Necessary Treatment required under Benefit 19.</p>	USD 1,000 USD 2,500

Key Product Provisions

6. Exclusions: What is not covered?

These are the **Plan** limitations that apply in addition to any personal exclusions detailed in **Your Certificate of Insurance**. These include **Treatments** that may be considered a matter of personal choice (such as cosmetic **Treatment**) and other **Treatments** that are excluded from cover to keep premiums at an affordable level.

6.1 Act of Terrorism, war and illegal acts

We do not pay for **Treatment** of any condition resulting directly or indirectly from, or as a consequence of war, acts of foreign hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, or attempted overthrow of government, or any acts of terrorism, unless **You** are an innocent bystander. **You** are not covered for costs arising from taking part in any illegal act.

6.2 Administrative and shipping fees

You are not covered for any charges made by a **Medical Practitioner** or **Dental Practitioner** for filling in claim forms or providing medical reports. **You** are not covered for any charges where a police report is required. **You** are not covered for the cost of shipping (including customs duty) on transporting medication.

6.3 Alcohol and drug abuse

You are not covered for costs for **Treatment** resulting from dependency on or abuse of alcohol, drugs, or other addictive substances and any illness or injury arising directly or indirectly from such dependency or abuse.

6.4 Chemical exposure

You are not covered for **Treatment** costs directly or indirectly caused by or contributed to or arising from: ionizing radiations or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel; the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

6.5 Cosmetic surgery

You are not covered for **Treatment** costs relating to cosmetic or aesthetic **Treatment** or any **Treatment** related to previous cosmetic or reconstructive surgery (whether or not for psychological purposes), such as but not limited to acne, teeth whitening, lentigo and alopecia.

6.6 Contamination

We do not pay for the **Treatment** of any conditions, or for any claim arising directly or indirectly from chemical or biological contamination, however caused, or from contamination by radioactivity from any nuclear material whatsoever, or asbestosis, including expenses in any way caused by or contributed to by an act of war or terrorism.

6.7 Chronic Conditions

If **You** are insured under the Essential **Plan** option, **You** do not have cover for costs relating to the maintenance of **Chronic Conditions**. For the Advance **Plan** option, the limits in the **Benefit Schedule** are a maximum per **Period of Cover** and not per **Medical Condition**.

6.8 Dental care

You are not covered for any dental care unless these **Benefits** are included on **Your Certificate of Insurance**. However **We** will pay for **Emergency In-Patient** dental **Treatment** following an **Accident** as detailed in the **Benefit Schedule**. **We** will not pay for any telephone or travelling expenses incurred in seeking dental advice or **Treatment**, damage to dentures unless being worn at the time of the **Accident**, or the cost of **Treatment** made necessary by an accidental dental injury if:

- The injury was caused by eating or drinking anything, even if it contains a foreign body
- The damage was caused by normal wear and tear
- The injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn
- The injury was caused by any means other than extra-oral impact
- The damage was caused by tooth brushing or any other oral hygiene procedure
- The damage is not apparent within 10 days of the impact which caused the injury
- The costs are incurred more than 18 months after the date of the injury which made the **Treatment** necessary

6.9 Developmental disorders

You are not covered for **Treatment** of developmental, behavioural or learning problems such as attention deficit hyperactivity syndrome, speech disorders or dyslexia and physical developmental problems.

6.10 Dietary supplements

We do not pay for naturally available substances that can be purchased without prescription, including but not limited to vitamins, minerals, and organic substances.

6.11 Eating disorders

You are not covered for costs relating to **Treatment** of eating disorders such as, but not limited to, anorexia nervosa and bulimia.

6.12 Excess or Co-Insurance

You are not covered for the amount of the **Excess** or **Co-Insurance** that is shown on **Your Certificate of Insurance**. **We** will treat any arrangement with or any offer by a provider to charge **Us** a higher fee to cover the amount of the **Excess** or **Co-Insurance** as fraud and **We** will take legal action.

6.13 Experimental Treatment and drugs

You are not covered for **Treatment** or drugs which have not been established as being effective or which are experimental. For drugs this means they must be licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and be used within the terms of that licence. For established **Treatment**, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced and published medical journals and/or been approved by the National Institute for Health and Clinical Excellence for specific purposes to be considered proven safe and effective therapies.

6.14 Eyes and ears

You are not covered for routine eyesight or hearing tests or the cost of eyeglasses, contact lenses, hearing aids or cochlear implants. **We** do not pay for eye surgery to correct vision, however eye surgery to correct an **Eligible Medical Condition** is covered.

6.15 External Prosthesis

You are not covered for any costs relating to providing, maintaining and fitting of any external prosthesis or appliance or other equipment, medical or otherwise except as is specified under the **Hospital Charges**, **Medical Practitioner** and **Specialist** fees **Benefit**.

6.16 Failure to follow medical advice

We do not pay for **Treatment** arising from or related to **Your** unreasonable failure to seek or follow medical advice and/or prescribed **Treatment**, or **Your** unreasonable delay in seeking or following such medical advice and/or prescribed **Treatment**. We do not pay for complications arising from ignoring such advice.

6.17 Foetal surgery

We do not cover the costs of surgery on a child while in its mother's womb except as part of the maternity **Benefits** detailed in **Your Certificate of Insurance**.

6.18 Genetic testing

We do not cover the cost of genetic tests, when those tests are undertaken to establish whether or not **You** may be genetically disposed to the development of a **Medical Condition**.

6.19 HIV, AIDS or sexually transmitted disease

You are not covered for **Treatment** for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by or related to Human Immunodeficiency Virus (HIV) (or both) and sexually transmitted disease, other than stated in the **Benefit Schedule**.

6.20 Morbid obesity

You are not covered for the costs of **Treatment** for, or related to, morbid obesity. **You** are not covered for costs arising from or relating to removing fat or surplus healthy tissue from any part of the body.

6.21 Nursing homes, convalescence homes, health hydros, and nature cure clinics

You are not covered for **Treatment** received in nursing homes, convalescence homes, health hydros, nature cure clinics or similar establishments. **You** are not covered for convalescence or where **You** are in **Hospital** for the purpose of supervision. **You** are not covered for extended nursing care if the reason for the extended nursing care is due to age related infirmity and/or if the **Hospital** has effectively become **Your** home.

6.22 Pre-Existing Medical Conditions

Your Plan does not cover **You** for **Treatment** of **Pre-Existing Medical Conditions** and **Related Conditions** unless accepted by Us in writing.

A **Pre-Existing Medical Condition** means any disease, injury or illness for which:

1. **You** have received **Treatment**, test or investigations for, been diagnosed with or been hospitalised for; or
2. **You** have suffered from or experienced symptoms; whether the **Medical Condition** has been diagnosed or not, at any time before your **Start Date/Entry Date** into the **Plan**.

6.23 Pregnancy or maternity

You are not covered for costs relating to normal **Pregnancy** or childbirth, voluntary caesarean section, unless maternity **Benefits** are shown on **Your Certificate of Insurance**.

6.24 Professional sports

You are not covered for any costs resulting from injuries or illness arising from **You** taking part in any form of professional sport. By professional sport, **We** mean where **You** are being paid to take part.

6.25 Reproductive medicine

You are not covered for costs relating to investigations into or **Treatment** of infertility and fertility, sterilisation (or its reversal) or assisted conception. **You** are not covered for the costs in connection with contraception.

6.26 Routine examinations, health screening

You are not covered for routine medical examinations including issuing medical certificates, health screening examinations or tests to rule out the existence of a condition for which **You** do not have any symptoms, unless these **Benefits** are shown on **Your Certificate of Insurance**.

6.27 Second opinions

We do not cover the costs of any second or subsequent medical opinions from a **Medical Practitioner** or **Specialist** for the same **Medical Condition** other than stated in **Your Certificate of Insurance**, unless authorised by **Us**.

6.28 Self-inflicted injuries or attempted suicide

You are not covered for any costs for **Treatment** resulting directly or indirectly from self-inflicted injury, suicide or attempted suicide.

6.29 Sexual problems and gender re-assignment

You are not covered for **Treatment** costs relating to sexual problems including sexual dysfunction or gender re-assignment operations or any other surgical or medical **Treatment** including psychotherapy or similar services which arise from, or are directly or indirectly associated with gender re-assignment. **You** are not covered for the costs of treating sexually transmitted infections.

6.30 Sleep disorders

You are not covered for **Treatment** costs related to snoring, insomnia, jet-lag, fatigue, or sleep apnoea including sleep studies or corrective surgery.

6.31 Travel/accommodation costs

You are not covered for transport or accommodation costs **You** incur during trips made specifically to get medical **Treatment** unless these costs are for an **Emergency** medical **Evacuation** that **We** pre-authorise. **You** are not covered for any costs of **Emergency** medical **Evacuation** or repatriating **Your** body that **We** did not pre-authorise and arrange.

6.32 Travelling against medical advice

You are not covered for medical or other costs **You** incur if **You** travel against the advice given by **Your** treating **Medical Practitioner**.

6.33 Treatment by a family member

You are not covered for the costs of **Treatment** by a family member or for self-therapy.

6.34 Treatment charges outside of Our reasonable and customary range

We will not pay **Treatment** charges when they are above the **Reasonable and Customary Charges** level.

7. Plan administration

7.1 The contract

The application form and any supporting documents, **Certificate of Insurance**, **Benefit Schedule** and this handbook incorporating the **Plan** terms and conditions make up the contract between **You** and **Us**.

7.2 Premium payment

At the start of each **Plan** year, **We** will calculate **Your** new premium and let **You** know how much it is. **We** offer a choice of monthly, quarterly, semi-annual or annual premiums, which can be paid by credit card. Bank transfers or cheques can be used for annual premiums only. Premiums are payable for each person covered and any increase will normally take effect from the annual **Renewal Date** of **Your** membership.

If **You** pay by credit card, bank transfer or cheque, **We** will collect the first premium when **Your Plan** starts and subsequent premiums when they fall due. However **You** pay **Your** premium at the moment, bear in mind that **You** can change to another method simply by contacting **Our** Customer Service team on +65 6880 2300.

You must pay **Your** premium when it is due. Depending on **Your** preferred payment method, **You** must pay **Us** before the **Start Date**, the due date or within 30 days of **Our** written acceptance at the latest, if a cover note is issued. If **You** do not, **We** will cancel **Your Plan** and will not pay for any **Treatment** or **Benefit** entitlement arising after the date that the premium became due.

We make every effort to maintain premiums at as low a level as possible, without compromising the range and quality of the cover provided. **We** review premiums each year to take account of a range of statistical factors.

Typically the cost of premiums increases at a level higher than the Retail Price Index (RPI). **You** will receive reasonable notice of any changes in premium. **Your** premium will also include the amount of any insurance premium tax or other taxes or levies which are payable by law in respect of **Your Plan**.

Premiums are based on age at the **Entry Date** or subsequent **Renewal Date**. When the **Dependant** child is an **Insured Person**, the current age shown in the premium tables will apply.

7.3 Eligibility

7.3.1 Airline crew

You must be a current employee of an approved Airline and provide evidence of employment to enrol in this affinity programme.

7.3.2 Full medical underwriting

Full medical underwriting requires each person to be covered by **Our Plan** to complete and return an application form including the medical declaration. If **You** answer "Yes" to any of the questions, **You** will be required to provide details of the date of, and diagnosis; past/current and future known **Treatment**; details of the frequency and severity of symptoms including the date of the last episode. If available, **You** should provide any medical reports or test results with **Your** application. **You** may be required to complete a further medical questionnaire if **We** require more information. All information will be treated in strict confidence.

We rely on the information that **You** provide in the application form when **We** decide whether or not to accept **Your** application, and whether or not **We** need to apply special terms. Special terms are exclusions or conditions that **We** may apply to **Your** cover. If **You** submit a claim for the **Treatment** of any condition which **You** omitted to tell **Us** about here, or **You** omit to tell **Us** everything about any condition, **We** may refuse to pay that claim. **We** will tell **You** about any excluded **Medical Conditions**, restriction of coverage, and/or additional loading on **Your Certificate of Insurance**.

7.3.3 Dependants

Any **Dependants** generally must be covered under the same level of benefit **You** have, as the **Planholder**. A different level of **Benefits** can be selected that provides no more **Benefits** than the **Insured Person** has. For example, the **Insured Person** may have an Essential **Plan** option; they can decide to cover their **Dependant** on the Essential **Plan** option, but not the Advance **Plan** option.

7.3.4 Start Date

Cover starts on the **Start Date** shown on **Your Certificate of Insurance** provided **We** have received **Your** premium payment. Depending on the preferred premium payment method, a cover note may be issued and premiums will be due within 30 days of **Our** written acceptance.

7.3.5 Local legislation

Membership may depend on local insurance licensing legislation in **Your Country of Residence**. **You** are obliged to meet local legislation requirements in **Your Country of Residence** at any time before and while **You** are a member of this **Plan**.

7.3.6 Non-Eligible residency

If **You** permanently reside in a country that is not covered by this **Plan** and which **We** have advised at **Renewal Date**, **You** are not **Eligible** for this **Plan**. For details of the excluded countries please contact **Our** Customer Service team on +65 6880 2300.

7.4 Adding a new Dependant

If subsequently **You** wish to add **Your** spouse, partner or child to **Your Plan**, **You** must either use **Your** online secure portfolio area at www.now-health.com or complete an add dependant application form. Cover will not start until **Your** application has been accepted by **Us** for that **Dependant** and **We** have received premium payment.

7.5 Adding New Borns

You can apply to add **New Born** babies (who are born to the **Planholder** or the **Planholder's** spouse) to the **Plan** from their date of birth. This can normally be done without filling out details of their medical history, provided **You** add them within 30 days of their date of birth. **You** can do this by applying via **Your** online secure portfolio area at www.now-health.com.

However, **We** will require details of the baby's medical history if the baby has been adopted, or was born as the result of any method of assisted conception or following any type of fertility **Treatment**, including but not limited to fertility drug **Treatment**. In such circumstances **We** reserve the right to apply particular restrictions to the cover **We** will offer, and **We** will notify **You** of those terms as soon as reasonably possible.

This may limit **Your** baby's cover for existing **Medical Conditions**. This would mean that **Your** baby will not be covered for **Treatment** carried out for **Medical Conditions** which existed prior to joining, such as **Treatment** in a Special Care Baby Unit and **You** will be liable for these costs.

7.6 Changing Your cover

Subsequent changes in cover can only be made at renewal.

7.7 Renewing Your cover

Your Plan is for one year, the **Period of Cover**. Prior to the end of any **Period of Cover** **We** will write to the **Planholder** to advise on what terms the **Plan** will continue, provided the **Plan** **You** are on is still available. Upon renewal **You** will be asked to reconfirm **Your** employment status including provision of evidence. If upon renewal **You** are no longer eligible for the affinity **Plan** **You** can be transferred to one of our standard Individual policies without additional underwriting. If **We** do not hear from the **Planholder** in response, **We** will renew **Your Plan** on our standard individual plan and terms. Where **You** have opted to pay premiums by continuous credit card payments or other payment method, **We** may continue to collect premiums by such method for the new **Plan** year. Please note that if **We** do not receive **Your** premium, **You** will not be covered. If the **Plan** **You** were on is no longer available, **We** will do **Our** best to offer **You** cover on an alternative **Plan**.

7.8 Continuous transfer terms

We will maintain **Your** existing underwriting or special acceptance terms, as shown by **Your** current insurer, such as any moratoria or specific exclusions and **Your Plan** with **Us** will be governed by the terms and conditions of this **Plan**. The acceptance by **Us** of **Your** original **Start Date** will be applied to **Your Plan** with **Us** and any transfer will be subject to no enhanced **Benefits** being provided. Transfer from a Company **Plan** to an Individual **Plan** is subject to written agreement from **Us**.

7.9 Local taxes

You are liable for any local taxes and charges as established by the applicable laws. These have to be paid in full by **You** and will be shown on **Your Certificate of Insurance**.

8. Making a complaint

8.1 Not happy with our service?

We hope you never need to raise concerns about our service or any aspect of your policy. However, if you do, please contact us and we will do our best to resolve things for you. Your complaint will be acknowledged on receipt and within three business days. If having contacted us you feel we have not put things right, please contact:

The General Manager
Now Health International (Singapore) Pte. Ltd
c/o Tenet Sompo Insurance Pte. Ltd.
50 Raffles Place,
#05-01/06 Singapore Land Tower
Singapore 048623

The General Manager is responsible for Now Health's Singapore Complaint Handling Policy and he will ensure that your complaint is investigated thoroughly and a full response is sent to you as soon as possible.

To allow us to investigate your complaint fully, the Monetary Authority of Singapore (MAS) gives us seven business days to get back to you requesting further information, from the date you first raised your complaint with us. However, we will respond sooner than this if we are able. We hope to either resolve your complaint or provide an update on our investigation within 14 days.

If following our investigation, you remain dissatisfied or we are unable to provide a response, you may write to the Principal Officer at Tenet Sompo Insurance Pte. Ltd requesting that they review your complaint. The address you need to write to is:

Tenet Sompo Insurance Pte. Ltd.
50 Raffles Place
#05-01/06 Singapore Land Tower
Singapore 048623

8.2 What regulatory protection do I have?

Plan Owners' Protection Scheme

This **Plan** is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC).

Coverage for your **Plan** is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please visit www.tenetsompo.com.sg/FAQ or the General Insurance Association of Singapore (GIA)/Life Insurance Association of Singapore (LIA) or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

8.3 What we do with your personal data

Please ensure that **You** show the following information to others covered under **Your Plan**, or make them aware of its contents.

We and the **Underwriters** will deal with all personal information supplied in the strictest confidence as required by the Personal Data Protection Act. **We** and **Your** Underwriters collect personal information about **You** and **Your Dependants** (including health, bank account and occupation) for the purpose of establishing and administering **Your Plan**. This includes information supplied by **You**, those family members, medical providers or **Your** employer (if applicable). **Your** information may be passed to Now Health group companies administering **Your Plan**, **Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside Singapore. Confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside Singapore. In certain circumstances medical service providers (or others) may be asked to supply further information. **Your** personal details will not be disclosed to other organisations without **Your** consent.

You have a right of access to, and correction of, information that **We** hold about **You**. Please contact **Us** if **You** would like to exercise either of these rights. Some of the information **We** collect about **You** may be classified as “sensitive” – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain **Your** explicit consent before **We** process the information.

When **You** provide information about family members, **We** will take this as confirmation that **You** have their consent to do so. As the legal holder of the **Plan** all correspondence about the **Plan**, including claims correspondence, will be sent to the **Planholder**. If any family member over 18 insured under the **Plan** does not want this to happen they should apply for their own **Plan**.

There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies relating to suspicions of fraudulent claims and other crimes. If required, information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including fraud or otherwise improper claims where there is reasonable suspicion. This may involve adding non-medical information to a database that will be accessible to other insurers and law enforcement agencies. Additionally, the General Medical Council or other relevant regulatory body will be notified about any issue where there is reason to believe a **Medical Practitioner's** fitness to practise may be impaired.

Now Health International group companies providing IPMI products may contact **You** by letter, SMS or email with details of other IPMI or related products and services which may be of interest to **You**. If **You** do not wish this to happen please tick this box ☐. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com.

If **You** change **Your** mind about this permission, please contact **Our** Customer Services team or write to **Us** at the address on the back of this handbook. Unless **You** inform **Us** otherwise **We** will assume that, for the time being, **You** are happy to be contacted in this way.

9. Rights and responsibilities

The application form, **Certificate of Insurance**, **Benefit Schedule** and this handbook incorporating the **Plan** terms and conditions make up the contract between **You** and **Us** with the purpose of providing **You** with **Benefit** when **You** need medical **Treatment**.

9.1 Your rights and responsibilities

9.1.1 **You** must make sure that whenever **You** are required to give **Us** any information, all the information **You** give **Us** is sufficiently true, accurate and complete so as to give **Us** a fair presentation of the risk **We** are taking on.

If **We** discover later it is not, then **We** can cancel the **Plan** or apply different terms of cover in line with the terms **We** would have applied had the information been presented to **Us** fairly in the first place.

9.1.2 **You** must write and tell **Us** if **You** change **Your** address or occupation.

9.1.3 This **Plan** is available only to people living outside their **Country of Nationality** apart from certain countries where **We** have explicitly agreed to cover local nationals, so **You** must tell **Us** immediately if **You** or any family member has gone to live in **Your Country of Nationality** – which means they will be in that country for more than six months in the year. **You** must tell **Us** if **You** change **Your** principal **Country of Residence**. If **You** don't tell **Us** **We** can refuse to pay **Benefits** claimed for.

9.1.4 Only **We** and the **Planholder** have legal rights under this **Plan** and it is not intended that any clause or term of this **Plan** should be enforceable, by any other person including any family member.

9.1.5 If the **Planholder** dies and there is more than one **Insured Person** aged 18 or above, this **Plan** will automatically be transferred to the oldest **Insured Person** from the date of death, who will become the **Planholder**.

9.1.6 **You** must pay **Your** premium when it is due and in the currency of **Your Plan**. **We** will decide the amount at the start of each year and tell **You** how much it is. **You** can pay it in the way **You** have agreed with **Us**. **We** can change the amount of **Your** premium during a year to reflect any change in insurance premium tax or other taxes but **We** will tell **You** of the change. If **Your** premium payments are not up to date **Your Plan** will end.

9.1.7 *RIGHT TO RETURN POLICY*

(This clause applies where the **Plan** is issued to an Individual. Not applicable to **Plan** renewals) Notwithstanding any general conditions to the contrary within this insurance, the first inception **Plan** may be returned to the **Us** for cancellation at any time within fourteen (14) days of receipt in the event the **Planholder** is not satisfied with the **Plan** for any reason. **We** will refund any premium paid or billed to the **Planholder**, in which case the **Plan** will be deemed as void from inception and **We** shall not be liable for any claims occurring prior to the return of the **Plan**. If **You** incur **Eligible** claims costs within that **Period of Cover** **We** reserve the right to require the **Planholder** to pay for the services **We** have actually provided in connection with the **Plan** to the extent permitted by law and any return of premium is subject to this. If the **Planholder** does not cancel the **Plan** during the cancellation period the **Plan** will continue on the terms described in this handbook for the remainder of the **Period of Cover**.

We may end cover for **You** (as the **Insured Person**) and **Your Dependants** in the following situations. If **You** or **Your Dependants**:

- Withhold relevant information or give **Us** incorrect information
- Make any false or fraudulent claim
- Fail to provide any reasonable information **We** have asked for
- Fail to pay the premiums due
- If **You** move to the USA, or a country not covered by this **Plan** which may vary from time to time, of which **You** will be advised

9.1.8 If **You** have an **Out-Patient Direct Billing** membership card, it is **Your** responsibility to return all such cards for **You** and **Your Dependants** to **Us** if **You** cancel or do not renew **Your Plan**. **We** will not be liable for any misuse by **You** of such **Out-Patient Direct Billing** membership cards.

9.1.9 This **Plan** shall be governed by and construed in accordance with the Laws of Singapore and the parties agree to submit to the jurisdiction of the Singapore courts.

9.2 Our rights and responsibilities

9.2.1 **We** will tell the **Planholder** in writing the date the **Plan** starts and any special terms which apply to it. **We** can refuse to give cover and will tell **You** if **We** do.

9.2.2 If for whatever reason there is a break in **Your** cover, **We** may reinstate the cover if the premium is subsequently paid, though terms of cover may be subject to variation. Any acceptance by **Us** is subject to **Our** written consent and **Your** acceptance.

9.2.3 **We** can refuse to add a family member to the **Plan** and **We** will tell the **Planholder** if **We** do.

9.2.4 **We** will pay for **Eligible** costs incurred during a period for which the premium has been paid.

9.2.5 If **You** break any of the terms of the **Plan** which **We** reasonably consider to be fundamental, **We** may (subject to 9.2.7) do one or more of the following:

- Refuse to make any **Benefit** payment or, if **We** have already paid **Benefits**, **We** can recover from **You** any loss to **Us** caused by the break
- Refuse to renew **Your Plan**
- Impose different terms to any cover **We** are prepared to provide
- End **Your Plan** and all cover under it immediately

9.2.6 Waiver by **Us** of any breach of any term or condition of this **Plan** shall not prevent the subsequent enforcement of that term or condition and shall not be deemed to be a waiver of any subsequent breach.

9.2.7 If **You** (or anyone acting on **Your** behalf) make a claim under **Your Plan** knowing it to be false or fraudulent, **We** can refuse to make **Benefit** payments for that claim and may declare the **Plan** void, as if it never existed. If **We** have already paid the **Benefit** **We** can recover those sums from **You**. Where **We** have paid a claim later found to be fraudulent, (whether in whole, or in part), **We** will be able to recover those sums from **You**.

9.2.8 **We** retain all rights of subrogation. **You** have no right to admit liability for any event or give any undertaking, which is binding upon **You**, **Your Dependants** or any other person named in the **Certificate of Insurance** without **Our** prior written consent.

9.2.9 **We** may alter the handbook terms or **Benefit Schedule** from time to time, but no alteration shall take effect until the next annual **Renewal Date**. **We** shall notify such changes to **You** in writing by sending the details to the primary contact details **We** have for **You**. **We** reserve the right to revise or discontinue the **Plan** with effect from any **Renewal Date**. No variation or alteration will be admitted unless it is in writing and signed on behalf of **Us** by an authorised employee.

9.2.10 This **Plan** is written in English and all other information and communications to **You** relating to this **Plan** will also be in English unless **We** have agreed otherwise in writing.

9.2.11 CONDITION PRECEDENT IN THE PLAN

The validity of this **Plan** is subject to the condition precedent that:

- (a) For the risk insured, the named insured has never had any insurance terminated in the last twelve (12) months due solely or in part to a breach of any premium payment condition; or
- (b) If the named insured has declared that it has breached any premium payment condition in respect of a previous policy taken up with another insurer in the last twelve (12) months:
 - (i) The named insured has fully paid all outstanding premium for time on risk calculated by the previous insurer based on the customary short period rate in respect of the previous policy; and
 - (ii) A copy of the written confirmation from the previous insurer to this effect is first provided by the named insured to the Company before cover incept.

9.2.12 PAYMENT BEFORE COVER WARRANTY (1 May 2005)

This clause applies where the **Plan** is issued to an Individual.

- (a) Notwithstanding anything herein contained but subject to clauses 2 and 3 hereof, it is hereby agreed and declared that the total premium due must be paid and actually received in full by **Us** (or the intermediary through whom this **Plan** or Bond was effected) on or before the inception date ("the inception date") of the coverage under the **Plan**, Bond, Renewal Certificate, Cover Note or Endorsement.
- (b) In the event that the total premium due is not paid and actually received in full by **Us** (or the intermediary through whom this **Plan** or Bond was effected) on or before the inception date referred to above, then the **Plan**, Bond, Renewal Certificate, Cover Note and Endorsement shall not attach and no benefits whatsoever shall be payable by **Us**. Any payment received thereafter shall be of no effect whatsoever as cover never attached on the **Plan**, Bond, Renewal Certificate, Cover Note and Endorsement.
- (c) In respect of coverage with "Free Look" provision, the Insured may return the original policy document to **Us** or intermediary within the "Free Look" period if the Insured decides to cancel the cover during the "Free Look" period. In such an event, the **Insured Person** will receive a full refund of the premium paid to **Us** provided that no claim has been made under the insurance.

9.2.13 SANCTION LIMITATION AND EXCLUSION CLAUSE

No insurer shall be deemed to provide cover and no insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, Japan, United Kingdom or United States of America.

9.2.14 TERRORISM EXCLUSION ENDORSEMENT

Notwithstanding any provision to the contrary within this insurance or any endorsement thereto it is agreed that this insurance excludes loss, damage cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any act of terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this endorsement an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

This endorsement also excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.

If the **Underwriters** allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this insurance the burden of proving the contrary shall be upon the Assured. In the event any portion of this endorsement is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

9.2.15 CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 2001

A person who is not a party to this **Plan** contract shall have no right under the Contracts (Rights of Third Parties) Act 2001 to enforce any of its terms.



ASIA INSURANCE
TECHNOLOGY AWARDS
2013 E-COMMERCE AWARD



► Now Health International

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