Summit 1750–5000

Benefits Schedule

2019
USD

For plans starting on or after 1 August 2019

aetna™

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M016-26E-010819

At a glance

Overall plan limit

Summit 1750 Up to 1,750,000 USD

Summit 2500 Up to 2,500,000 USD

Summit 4000 Up to 4,000,000 USD

Summit 5000 Up to 5,000,000 USD

Annual excess

This is the total **excess** each **member** needs to pay towards **claims** in the **plan year**.

Summit 1750
Nil, 1,000 USD, 2,000 USD or 4,000 USD, as shown on your Certificate of Insurance.

Summit 2500, 4000 and 5000
No annual **excess**

Outpatient coinsurance

This is the percentage of **coinsurance** each **member** needs to pay towards **claims** in the **plan year**.

Summit 1750
No **outpatient coinsurance**.

Summit 2500, 4000 and 5000
0%, 10% up to a maximum 2,000 USD, 20% up to a maximum 4,000 USD or 30% up to a maximum 5,000 USD, as shown on your **Certificate of Insurance**.

Good to know

Using this Benefits Schedule

Some words and phrases have specific meanings, **we**'ve highlighted them in bold print and **you**'ll find their definitions in your Handbook.

This **Benefits Schedule** details the **plan benefits** available under the core Summit **plan**. The **plan sponsor** may also be able to add and remove **benefits**, and increase or decrease **benefit** limits to enable them to custom-build a solution that's right for them and their business.

Before you're treated

It's important **you** request **our** approval before **you** receive **treatment** for the following **treatments** and services:

- Medical evacuation
- **Inpatient** or **daycare treatment** admission
- Psychiatric **treatment**
- Prescription for more than three months' supply of drugs for a **chronic medical condition**
- Single **treatment** or service that costs more than 500 USD or equivalent

If **you**'re unable to ask for approval because it's an **emergency**, **you** or someone on your behalf must let **us** know about the **emergency** within 24 hours.

Your deductibles

Annual excess

An annual **excess** applies to Summit 1750. This is the total **excess** each **member** needs to pay towards **claims** in the **plan year** and applies to all **benefits**, except where explicitly stated in sections: 6 Cancer Care, 19 Dental treatment, 20 Optical care, 21 Wellness, 22 Pregnancy and Childbirth and 24 Hospital cash. Your chosen annual **excess** is shown on your **Certificate of Insurance**.

Outpatient coinsurance

We'll apply your level of **outpatient coinsurance**, as shown on your **Certificate of Insurance**, to **outpatient claims**. Once the total amount of **outpatient coinsurance you** have paid in a **plan year** reaches the maximum amount, **you** won't have to pay any more **outpatient coinsurance.**

Dental coinsurance

We'll apply **our dental coinsurances** to **dental claims** under the **dental benefits** only. See 19 Dental treatment.

What's covered

The **benefits** noted below are subject to the terms, conditions and exclusions contained in your **plan documents**. **We**'ll only pay reasonable costs for **claims** for **treatment** and services that are **benefits** and are **medically necessary**. Reasonable costs are the average cost of **treatment**, expertise or services given by similar types of medical provider within the same country or geographical region, based on **our** knowledge, experience and reasonable opinion.

1 Overall plan limit	Summit **1750**	Summit **2500**	Summit **4000**	Summit **5000**
We'll pay reasonable costs for **benefits** up to the overall **plan** limit for each **member** in each **plan year**. **Benefit** limits shown as 'Paid in full' are subject to the overall **plan** limit for each **member** in each **plan year**.	**1,750,000 USD**	**2,500,000 USD**	**4,000,000 USD**	**5,000,000 USD**
If **you** are a Hong Kong resident, costs for **hospital** accommodation, **treatment** and services in Hong Kong will only be paid up to the reasonable and customary rates associated with a semi-private dual occupancy room. This applies for all **inpatient** and **daycare** costs covered under: 2 Inpatient and daycare treatment 3 Parent accommodation 5 Rehabilitation 6 Cancer care 8 Physiotherapy and complementary medicine 9 Psychiatric treatment 11 Congenital abnormalities 12 HIV or AIDS 13 Organ transplants 14 Terminal care 19 Dental treatment 22 Pregnancy and childbirth. *i For non-Hong Kong residents, and Hong Kong residents receiving **treatment** outside of Hong Kong, **we**'ll pay for **hospital** accommodation (including meals) up to the cost of a standard single room with a private bathroom.*	Not applicable or Paid in full for semi-private room only	Not applicable or Paid in full for semi-private room only	Not applicable or Paid in full for semi-private room only	Not applicable or Paid in full for semi-private room only

2 Inpatient and daycare treatment

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Medical costs including intensive care, theatre, **hospital** accommodation, **medical practitioners, specialists**, anaesthetists, nursing, **appliances** and prescribed drugs and dressings.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
Kidney dialysis.				
MRI, PET and CT scans, X-rays, pathology and other **diagnostic tests and procedures.**				
Reconstructive surgery to restore natural function or appearance within 12 months of an **accident** or surgery.				
Speech and language therapy and occupational therapy as part of your **inpatient treatment**.				
Medical services of a **nurse** that would have been part of your **inpatient** or **daycare treatment** when these are received in your home instead of in **hospital**.				
All **inpatient treatment** needed for **acute medical conditions** that begin before the **member** is eight days old, if the **member** was conceived by natural conception.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
Where **we** agree that parent accommodation is needed in relation to this **benefit** and would normally be paid under section 3 Parent accommodation, it will be paid under this section instead.				

3 Parent accommodation

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Hospital accommodation costs for a parent or legal guardian to stay with the **member** if they aged 17 or under and receiving **inpatient treatment** that **we** cover under 2 Inpatient and daycare treatment.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full

4 Outpatient post-hospitalisation treatment

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Outpatient treatment for 90 days after **you**'re discharged following **inpatient** or **daycare treatment** for the same **acute medical condition**. This **benefit** covers **medical practitioners'** and **specialists'** fees, surgical procedures, prescribed drugs and dressings, MRI, PET and CT scans, X-rays, pathology and other **diagnostic tests and procedures**.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

5 Rehabilitation

This **benefit** is only available if:

- **you**'ve received **inpatient treatment** for three or more consecutive days for the same **medical condition,**
- **you**'ve stayed in hospital for three or more consecutive nights for the same **medical condition**,
- your **inpatient treatment** was covered under 2 Inpatient and daycare treatment,
- a **medical practitioner** or **specialist** has referred **you** for rehabilitation, and
- your rehabilitation starts:
  - after **you**'re discharged from **hospital** following your **inpatient treatment**, or
  - when **you**'re transferred to a rehabilitation unit following your **inpatient treatment**.

Your first session must be no more than 14 days after **you**'re discharged or transferred.

This **benefit** covers **inpatient**, **daycare** and **outpatient** physiotherapy, speech and language therapy and occupational therapy. **We**'ll also pay for accommodation costs at the rehabilitation unit when **medically necessary**.

*This section applies before any available **benefit** limit shown in 8 Physiotherapy and complementary medicine.*

Summit 1750	Summit 2500	Summit 4000	Summit 5000
✔ Paid in full for up to 30 days after **you**'re discharged or transferred	✔ Paid in full for up to 60 days after **you**'re discharged or transferred	✔ Paid in full for up to 90 days after **you**'re discharged or transferred	✔ Paid in full for up to 120 days after **you**'re discharged or transferred

5 Rehabilitation Continued

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

6 Cancer care

All **treatment** for, or related to, a diagnosed cancer. This includes **palliative treatment** and care.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
*Annual **excess***	Not applicable	Not applicable	Not applicable	Not applicable

7 Outpatient treatment

Surgical procedures.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
Outpatient pre-operative tests up to 72 hours before **inpatient** or **daycare treatment** covered under 2 Inpatient and daycare treatment.	✓ Paid up to 1,000 USD	✓ Paid up to 5,000 USD	✓ Paid up to 15,000 USD	✓ Paid in full
Medical practitioners' and **specialists'** fees, prescribed drugs and dressings, MRI scans, X-rays, pathology and **diagnostic tests and procedures**.	Not covered			✓ Paid in full
Outpatient treatment for **medical conditions** that that are an **emergency** when the **treatment** is received in a **hospital**.	Not covered			✓ Paid in full
Kidney dialysis.	Not covered			✓ Paid in full

7 Outpatient treatment
Continued

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
PET and CT scans.	Not covered	✔ Paid in full	✔ Paid in full	✔ Paid in full
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

8 Physiotherapy and complementary medicine

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Physiotherapy as part of **inpatient** or **daycare treatment**. *Outpatient coinsurance doesn't apply.*	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Post-hospitalisation **outpatient** physiotherapy. This **benefit** is available for 90 days after each **inpatient** or **daycare** admission.	✔ Paid up to 750 USD			✔ Paid in full
Outpatient physiotherapy when a **medical practitioner** or **specialist** refers **you**. *We reserve the right to seek further information from your **medical practitioner** or therapist if **you** received further **treatment** after **you**'ve completed six sessions.*	Not covered	✔ Paid up to 1,500 USD	✔ Paid up to 2,000 USD	✔ Paid in full
Outpatient podiatry, osteopathic and chiropractic **treatment** when a **medical practitioner** or **specialist** refers **you**.	Not covered			✔ Paid up to 4,000 USD
Outpatient traditional Chinese medicine, ayurvedic medicine, acupuncture and homeopathic **treatment**.	Not covered	✔ Paid up to 300 USD	✔ Paid up to 750 USD	✔ Paid up to 1,500 USD

*We reserve the right to seek further information from your therapist if **you** received further **treatment** after **you**'ve completed four sessions for any one **medical condition**.*

8 Physiotherapy and complementary medicine Continued

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

9 Psychiatric treatment

Up to 30 days **inpatient** psychiatric **treatment** and psychotherapy in the **plan year**. *Outpatient coinsurance doesn't apply.*	Not covered	✓ Paid up to 5,000 USD	✓ Paid up to 10,000 USD	✓ Paid in full
Outpatient psychiatric **treatment** and psychotherapy.	Not covered	✓ Paid up to 1,000 USD	✓ Paid up to 2,000 USD	✓ Paid up to 10,000 USD
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

10 Durable medical equipment
including prosthetic and orthotic supplies

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
We'll cover costs for: • Items a **medical practitioner** or **specialist** prescribes which are needed to deliver prescribed drugs and apply dressings • Buying and fitting of devices or items **medically necessary** for **treatment** including spinal supports, orthopaedic braces and air cast boots • The rental or initial purchase of crutches or a wheelchair if **medically necessary** • The initial buying and fitting of external prostheses needed after surgery, including artificial eyes and limbs • The buying and fitting of **medically necessary** orthotic supplies, including insoles and orthotic supports This **benefit** does not extend to sight or hearing aids, furniture or any modifications to your personal or work environment. *If the costs are related to a **medical condition we** cover under the following sections, **we**'ll cover these within the **benefit** limits of that section:* 6 *Cancer care* 11 *Congenital abnormalities* 12 *HIV or AIDS* 13 *Organ transplants* 14 *Terminal care* 22 *Pregnancy and childbirth* 25 *Emergency treatment outside your area of cover*	✓ Paid up to 1,000 USD	✓ Paid up to 1,000 USD	✓ Paid up to 1,000 USD	✓ Paid up to 2,000 USD
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

11 Congenital abnormalities

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
All **treatment** for diagnosed **congenital abnormalities** and any **related medical conditions**. This includes **palliative treatment** and care for a **congenital abnormality** or any **related medical condition**. *We'll cover costs for an organ transplant for **congenital abnormalities** and any **related medical conditions** under section 13 Organ transplants.*	Not covered	✓ Up to a **lifetime limit** of 25,000 USD	✓ Up to a **lifetime limit** of 50,000 USD	✓ Up to a **lifetime limit** of 100,000 USD
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

12 HIV or AIDS

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
All **treatment**, including **palliative treatment** and care, for diagnosed HIV or AIDS and all **related medical conditions**.	Not covered	✓ Paid up to 5,000 USD	✓ Paid up to 10,000 USD	✓ Paid up to 15,000 USD
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

13 Organ transplants

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Kidney, pancreas, liver, heart or lung transplants and any related **treatment**.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

14 Terminal care

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Palliative treatment and care for a **medical condition** which is diagnosed as **terminal**. *If the costs are related to a **medical condition we** cover under the following sections, **we**'ll cover these within the **benefit** limits of that section:* 6 *Cancer care* 11 *Congenital abnormalities* 12 *HIV or AIDS*	Not covered	✔ Paid in full	✔ Paid in full	✔ Paid in full
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

15 Medical evacuation

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
The costs to transport **you** to the nearest appropriate medical facility when your **medical condition** is an **emergency** and **we** agree appropriate **treatment** is not available locally. This **benefit** extends to the costs for **emergency treatment you** receive during the journey. If **we** have transported **you** outside your **area of cover**, **we**'ll pay any related costs **you** incur in the country **you**'re evacuated to under the sections of your **Benefits schedule** that would normally apply when **you**'re within your **area of cover**.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Economy class travel costs for **you** to go back to your choice of your **country of residence**, or your **home country**, after your **emergency** medical evacuation that was covered under this **plan**.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Costs of one **dependant** or companion having to accompany **you** or to travel at the same time if they are not able to accompany **you** during the actual **emergency** medical evacuation. This **benefit** will only become available if your **medical condition** is **critical** or **you**'re expected to stay in **hospital** for seven or more nights. For the duration of your evacuation and period of admission **we**'ll cover: • Costs for return economy class travel, including taxi transfers to and from the hotel on arrival and departure • A taxi from the hotel to the **hospital**, and back, once a day • Reasonable overnight accommodation costs including breakfast	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
The costs to transport **you** to appropriate medical facilities to receive **treatment** when your **medical condition** is not an **emergency**. **We**'ll cover costs for return economy class travel to a location of your choice within your **area of cover** if: • **we** agree appropriate **treatment** is not available locally, and • **we** agree appropriate **treatment** is available in your chosen location. **We**'ll also cover costs for airport taxi transfers. Cover is only available under this **benefit** if the **treatment** is covered under 2 Inpatient or daycare treatment, or 4 Outpatient post-hospitalisation treatment to 14 Terminal care.	Not covered	Not covered	Not covered	Not covered

15 Medical evacuation
Continued

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
The costs to transport **you** to appropriate medical facilities for **treatment** related to your pregnancy if it's not an **emergency**. **We**'ll cover costs for return economy class travel to a location of your choice within your **area of cover** if: • **we** agree appropriate **treatment** is not available locally, and • **we** agree appropriate **treatment** is available in your chosen location. **We**'ll also cover costs for airport taxi transfers. **You**'re limited to three return journeys for each pregnancy. Cover is only available under this **benefit** if the **treatment** is covered under section 22 Pregnancy and childbirth and **you** have completed any waiting periods shown in section 22.	Not covered	Not covered	Not covered	Not covered

i ***You**'re not covered for air-sea rescue or any mountain rescue unless **you** suffer from a **medical condition** at a recognised ski or similar winter sports resort.*

16 Local ambulance

Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local **hospital** because of an **emergency** or if treatment is **medically necessary**. *i* *Cover is only available under this **benefit** if the **treatment** is covered under the following sections:* 2 *Inpatient and daycare treatment* 4 *Outpatient post-hospitalisation treatment* 6 *Cancer care* 7 *Outpatient treatment* 9 *Psychiatric treatment* 11 *Congenital abnormalities* 12 *HIV or AIDS* 13 *Organ transplants* 14 *Terminal care* 22 *Pregnancy and childbirth* ***You**'re not covered for air-sea rescue or any mountain rescue unless **you** suffer from a **medical condition** at a recognised ski or similar winter sports resort.*	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full

17 Mortal remains

Summit 1750	Summit 2500	Summit 4000	Summit 5000
✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full

If **you** die outside your **home country**, **we**'ll cover reasonable costs:

- to transport your body or mortal remains to your **home country** or your **country of residence** as directed by your next of kin or estate; or
- for your burial or cremation at the place of your death as directed by your next of kin or estate.

In the event of your burial, **we**'ll cover:

- the cost of opening or reopening a grave;
- any exclusive right of burial fee; and
- burial costs.

In the event of your cremation, **we**'ll cover:

- the cost of any doctor's certificates; and
- cremation costs, including the removal of any medical device before the cremation

This **benefit** does not extend to the purchase of a burial plot, or funeral costs, including, but not limited to, flowers and the funeral director's fees.

If **you** die within your **home country**, **we**'ll cover reasonable costs to transport your body to the place of your burial or cremation as directed by your next of kin or estate. This **benefit** does not extend to any costs related to your burial or cremation.

18 Compassionate emergency visit

Summit 1750	Summit 2500	Summit 4000	Summit 5000
Not covered	Not covered	✔ Paid in full	✔ Paid in full

Costs **you** have to pay for one economy class return travel ticket from your **area of cover** for **you** to:

- visit a **close family member** if their **medical condition** is **critica**l, or
- attend their burial or cremation following their death.

We'll cover a maximum of one return journey in the **plan year**.

19 Dental treatment

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Outpatient dental treatment for damage to **natural teeth** caused by an **accident** when: • the **treatment** can only be provided after **you**'ve received **inpatient treatment** related to the **accident**, and • **you** receive **treatment** within 90 days after **you**'re discharged from **hospital** for your related **inpatient treatment**. This **benefit** includes the cost to supply and fit **dental** implants.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Outpatient dental treatment for accidental damage to **natural teeth**, except when the damage is caused by eating. Cover is only available when **you** receive **treatment** for the accidental damage within 10 days of the **accident**. This **benefit** also includes one follow-up consultation within 30 days of the **accident**.	Not covered	✔ Paid up to 500 USD	✔ Paid up to 750 USD	✔ Paid up to 1,500 USD
*Annual **excess** applies*				
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD
Routine **outpatient dental treatment**, including **treatment** for accidental damage to **natural teeth** when the damage is caused by eating. This **benefit** covers **dental** examinations, scraping, cleaning and polishing, X-rays, composite fillings and simple non-surgical extractions only. Cover is available after **you**'ve had 182 days' continuous cover from the date that this optional **benefit** was first included in your **plan**. (Not applicable for MHD policies).	Not covered	Not covered	Not covered	Not covered
Major restorative **dental treatment**, including **treatment** for accidental damage to **natural teeth** when the damage is caused by eating. This **benefit** covers: • Surgical extractions, including wisdom teeth • Root canal **treatment** • The cost to supply, fit and repair crowns, bridges and dentures • X-rays needed to support major restorative **dental treatment** • Gum **treatment** Cover is available after **you**'ve had 182 days' continuous cover from the date that this optional **benefit** was first included in your **plan**. (Not applicable for MHD policies).	Not covered	Not covered	Not covered	Not covered

19 Dental treatment Continued

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Dental coinsurance	Not applicable	Not applicable	Not applicable	Not applicable
Outpatient dental treatment when your dental condition is an emergency	Not covered	Not covered	Not covered	Not covered
Orthodontic treatment including: • Orthodontic examinations • Costs to supply, fit and repair orthodontic devices or items • X-rays needed to support orthodontic treatment • Surgical and non-surgical extractions needed as part of your orthodontic treatment	Not covered	Not covered	Not covered	Not covered
Orthodontic coinsurance	50%	50%	50%	50%
Dental implants including: • Dental examinations needed for dental implants • Costs to supply, fit and repair dental implants • X-rays needed to support the fitting or repair of dental implants	Not covered	Not covered	Not covered	Not covered
Dental implants coinsurance	50%	50%	50%	50%
Annual excess	Not applicable	Not applicable	Not applicable	Not applicable

20 Optical care

Prescription costs for: • Contact lenses • Spectacles • Spectacle lenses • Spectacle frames You're also covered for one consultation and sight examination for the signs or symptoms, or management of, natural or non-medical degenerative sight disorders. This includes, but isn't limited to, myopia, hypermetropia and astigmatism.	Not covered	Not covered	Not covered	Not covered
Annual excess	Not applicable	Not applicable	Not applicable	Not applicable
Optical coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

21 Wellness

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Members aged 18 or over: **routine health checks** including cancer screening, cardiovascular examinations, neurological examinations, vital sign tests and vaccinations.	Not covered	Not covered	✓ Paid up to 500 USD	✓ Paid up to 1,000 USD
Members aged 17 or under: **routine health checks** and vaccinations.	Not covered	Not covered	✓ Paid up to 500 USD	✓ Paid up to 1,000 USD
One sight examination and one hearing examination in the **plan year**.	Not covered	Not covered	Not covered	✓ Paid up to 250 USD
Annual excess	Not applicable	Not applicable	Not applicable	Not applicable

22 Pregnancy and childbirth

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
• Antenatal checkups for an uncomplicated pregnancy (no more than 12 routine antenatal visits during each pregnancy and one routine 2D ultrasound scan in each trimester). • Antenatal vitamins • Delivery costs, nursing fees and **hospital** accommodation costs for uncomplicated childbirth • Postnatal checkups • **Hospital** accommodation costs for your newborn to stay with **you** for up to four nights immediately after his or her birth. **We**'ll also pay the following routine costs for the newborn for the first 30 days after his or her birth, even if **you** do not add the newborn to your **plan**: • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination This **benefit** also extends to the cost of elective circumcision for newborn males. Cover is available for up to 30 days from birth, and paid up to 500 USD within the **benefit** limit shown.	Not covered	Not covered	Not covered	Not covered
Maternity **coinsurance**	Not applicable	Not applicable	Not applicable	Not applicable

22 Pregnancy and childbirth
Continued

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Treatment for medical maternity complications during pregnancy or childbirth, if the pregnancy is the result of an assisted conception. **We**'ll also cover the following routine costs for the newborn for the first 30 days after his or her birth, even if **you** do not add your newborn to your **plan**: • **Hospital** accommodation costs for your newborn to stay with **you** immediately after a complicated childbirth • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination This **benefit** also extends to the cost of elective circumcision for newborn males. Cover is available for up to 30 days from birth, and paid up to 500 USD within the **benefit** limit shown.	Not covered	✓ Paid up to 5,000 USD	✓ Paid up to 5,000 USD	✓ Paid up to 5,000 USD
Maternity **coinsurance**	Not applicable	10%	10%	10%
*These **benefits** are only available after **you** have had 12 months' continuous cover from the date that the **benefit** was first introduced on your **plan**. (Not applicable for MHD policies).*				
Treatment for medical maternity complications during pregnancy or childbirth, if the pregnancy is the result of natural conception. **We**'ll also cover the following routine costs for the newborn for the first 30 days after his or her birth, even if **you** do not add your newborn to your **plan**: • **Hospital** accommodation costs for your newborn to stay with **you** immediately after a complicated childbirth • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination This **benefit** also extends to the cost of elective circumcision for newborn males. Cover is available for up to 30 days from birth, and paid up to 500 USD within the **benefit** limit shown.	Not covered	✓ Paid up to 15,000 USD	✓ Paid up to 15,000 USD	✓ Paid up to 50,000 USD

22 Pregnancy and childbirth
Continued

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
*The **benefit** limits shown in this section apply for each pregnancy. Where a pregnancy spans more than one **plan** year, any **benefit** paid for treatment or services received in the **plan** year when the pregnancy began will be deducted from the **benefit** limit shown in the following **plan** year.*				
*The **benefits** within this section do not extend to 3D or 4D ultrasound scans.*				
*Annual **excess***	Not applicable	Not applicable	Not applicable	Not applicable

23 Hormone replacement therapy

Hormone replacement therapy for symptoms of the menopause.	Not covered	Not covered	✓ Paid up to 500 USD	✓ Paid up to 500 USD
*Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

24 Hospital cash

We'll pay **you** for each night **you** stay in a **hospital** for **inpatient treatment**: • if the **inpatient treatment** and **hospital** accommodation **you** receive during your stay are provided free of charge, and • **we** would otherwise cover the **treatment** or services **you** receive during your stay under this **plan**. **We**'ll pay for a maximum of 20 nights in the **plan year**.	✓ 125 USD paid to **you** for each night	✓ 125 USD paid to **you** for each night	✓ 125 USD paid to **you** for each night	✓ 125 USD paid to **you** for each night
*Annual **excess***	Not applicable	Not applicable	Not applicable	Not applicable

25 Emergency treatment outside your area of cover

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
Inpatient and **daycare treatment** when your **medical condition** is an **emergency**. *i Outpatient coinsurance doesn't apply.*	✓ Paid up to 5,000 USD	✓ Paid up to 15,000 USD	✓ Paid up to 30,000 USD	✓ Paid up to 50,000 USD
Outpatient treatment when your **medical condition** is an **emergency**.	Not covered	✓ Paid up to 500 USD	✓ Paid up to 500 USD	✓ Paid up to 500 USD
*i Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD
Costs of the appropriate type of ambulance needed to transport **you** to the nearest appropriate local **hospital**. This **benefit** is only available when your **medical condition** is an **emergency**. *i We will only cover **you** if the **emergency** would be covered if **you** were within your **area of cover***	✓ Paid up to 500 USD	✓ Paid up to 500 USD	✓ Paid up to 500 USD	✓ Paid up to 500 USD
If the **emergency** is due to pregnancy or childbirth and **you**'re 26 weeks or more into your pregnancy, this **benefit** is only available if **you** have been outside your **area of cover** for no more than 14 days at your date of admission for **emergency inpatient** or **daycare treatment** or the date **you** receive **emergency outpatient treatment**. Travel must not be against the advice of a **medical practitioner**, **specialist** or **nurse** at any time during your pregnancy.				

26 Health management services

Access to **our** CARE team to receive tailored information and discuss any chronic condition and disease management.	Not included	✓ Included	✓ Included	✓ Included
Employee Assistance Programme – access to online and telephonic confidential support including counselling, information and guidance. Log on to the Health Hub or contact **our** Member Services Team for more information.	Not included	✓ Included	✓ Included	✓ Included
Employee Assistance Programme – access to in-person confidential support including counselling, information and guidance. Log on to the Health Hub or contact **our** Member Services Team for more information.	Not included	Not included	✓ Included	✓ Included

26 Health management services
Continued

	Summit 1750	Summit 2500	Summit 4000	Summit 5000
*We'll cover a maximum of five counselling sessions in each **plan year**.*				

27 red24 security services

AdviceLine: 24/7 personal security information and advice for all your travel safety queries. Visit www.red24.com/aetna to register for this service.	✓ Included	✓ Included	✓ Included	✓ Included
ActionResponse: 24/7 international rescue and response service for **you** in a potentially life-threatening, non-medical event. Visit www.red24.com/aetna to register for this service.	Not included	Not included		

All cover provided under this Benefits Schedule is subject to the terms of your plan documents.

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If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Warba and Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Asset Control (OFAC) license. For more information on OFAC, visit **www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

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Important: This is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.

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