



Summit 5000+

Benefits Schedule

2019
USD

For plans starting on or after 1 August 2019



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At a glance



Overall plan limit

Summit 5000+
Up to 5,000,000 USD



Outpatient coinsurance

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

Summit 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

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

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**.

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:

- 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](#)

Not applicable
or
Paid in full
for semi-private
room only

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.

2 Inpatient and daycare treatment

Medical costs including intensive care, theatre, **hospital** accommodation, **medical practitioners, specialists, anaesthetists, nursing, appliances** and prescribed drugs and dressings.

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.

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.

All **inpatient treatment** needed for **acute medical conditions** that begin before the **member** is eight days old, if the **member** was conceived by assisted conception.

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.

✓
Paid in full

✓
Up to a **lifetime limit** of 150,000 USD

3 Parent accommodation

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

4 Outpatient post-hospitalisation treatment

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

i Your outpatient coinsurance applies, as shown on your Certificate of Insurance.

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.

i This section applies before any available benefit limit shown in [8 Physiotherapy and complementary medicine](#).

✓
Paid in full
for up to 120 days
after your
discharged or
transferred

i Your outpatient coinsurance applies, as shown on your Certificate of Insurance.

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

7 Outpatient treatment

Surgical procedures.

✓
Paid in full

Outpatient pre-operative tests up to 72 hours before **inpatient** or **daycare treatment** covered under **2 Inpatient and daycare treatment**.

✓
Paid in full

Medical practitioners' and **specialists'** fees, prescribed drugs and dressings, MRI scans, X-rays, pathology and **diagnostic tests and procedures**.

✓
Paid in full

Outpatient treatment for medical conditions that are an **emergency** when the **treatment** is received in a **hospital**.

✓
Paid in full

Kidney dialysis.

✓
Paid in full

PET and CT scans.

✓
Paid in full

i Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.

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

Physiotherapy as part of **inpatient** or **daycare treatment**.

✓
Paid in full

i **Outpatient coinsurance doesn't apply**

Post-hospitalisation **outpatient** physiotherapy. This **benefit** is available for 90 days after each **inpatient** or **daycare** admission.

✓
Paid in full

Outpatient physiotherapy when a **medical practitioner** or **specialist** refers you.

i 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.

✓
Paid in full

Outpatient podiatry, osteopathic and chiropractic **treatment** when a **medical practitioner** or **specialist** refers you.

✓
Paid up to
4,000 USD

Outpatient traditional Chinese medicine, ayurvedic medicine, acupuncture and homeopathic **treatment**.

✓
Paid up to
1,500 USD

i 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**.

i Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.

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.

i Outpatient coinsurance doesn't apply

Outpatient psychiatric treatment and psychotherapy.

i Your outpatient coinsurance applies, as shown on your Certificate of Insurance.

✓
Paid in full

✓
Paid up to
10,000 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

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.

i 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

i Your outpatient coinsurance applies, as shown on your Certificate of Insurance.

✓
Paid up to
2,000 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

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**.

✓
Up to a lifetime limit of 100,000 USD

All **treatment** for diagnosed **congenital abnormalities** and any **related medical conditions** that are diagnosed before an insured **member** is 31 days old:

- if the pregnancy is the result of natural conception,
- if they are added to the **plan** before they are 31 days old, and
- the **treatment** would normally be covered under the **lifetime limit** above.

✓
Paid in full

Once the **member** reaches five years of age, cover will only be available under the **lifetime limit** above. Any costs paid under this section will not be deducted from the **lifetime limit** shown above. If the pregnancy is the result of assisted conception, cover will only be available under the **lifetime limit** above.

i We'll cover costs for an organ transplant for **congenital abnormalities** and any **related medical conditions** under section **13 Organ transplants**.

i Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.

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

All **treatment**, including **palliative treatment** and care, for diagnosed HIV or AIDS and all **related medical conditions**.

✓
Paid up to 15,000 USD

i Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.

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

Kidney, pancreas, liver, heart or lung transplants and any **related treatment**.

✓
Paid in full

i Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.

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

Palliative treatment and care for a medical condition which is diagnosed as terminal.

i 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

i Your **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.

✓
Paid in full

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

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**.

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

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

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

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

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

17 Mortal remains

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.

✓
Paid in full

18 Compassionate emergency visit

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 critical, or
- attend their burial or cremation following their death.

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

✓
Paid in full

19 Dental treatment

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.

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**.

i Your *outpatient coinsurance applies, as shown on your Certificate of Insurance.*

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).

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).

✓
Paid in full

✓
Paid up to
1,500 USD

0% or
10% to max
2,000 USD or
20% to max
4,000 USD or
30% to max
5,000 USD

Not covered

Not covered

Dental coinsurance

Not applicable

Outpatient dental treatment when your **dental** condition is an **emergency**

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

Orthodontic coinsurance

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

Dental implants coinsurance

50%

20 Optical care

Prescription costs for:

- Contact lenses
- Spectacles
- Spectacle lenses
- Spectacle frames

Not covered

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.

Optical care **coinsurance**

Not applicable

21 Wellness

Members aged 18 or over: **routine health checks** including cancer screening, cardiovascular examinations, neurological examinations, vital sign tests and vaccinations.

✓
Paid up to
1,000 USD

Members aged 17 or under: **routine health checks** and vaccinations.

✓
Paid up to
1,000 USD

One sight examination and one hearing examination in the **plan year**.

✓
Paid up to
250 USD

22 Pregnancy and childbirth

- 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.

Maternity coinsurance

Not covered

Not applicable

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 the 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.

Maternity coinsurance

10%

i 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 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**:

- **Hospital** accommodation costs for the 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.

i 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.

i The **benefits** within this section do not extend to 3D or 4D ultrasound scans.

✓
Paid up to
40,000 USD

✓
Paid in full

23 Hormone replacement therapy

Hormone replacement therapy for symptoms of the menopause.

***i** Your outpatient coinsurance applies, as shown on your Certificate of Insurance.*

✓
Paid up to
500 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

25 Emergency treatment outside your area of cover

Inpatient and daycare treatment when your medical condition is an emergency.

***i** Outpatient coinsurance doesn't apply*

Outpatient treatment when your medical condition is an emergency.

***i** Your outpatient coinsurance applies, as shown on your Certificate of Insurance.*

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*

Not applicable
Area of cover is
worldwide

0% or
10% to max
2,000 USD or
20% to max
4,000 USD or
30% to max
5,000 USD

Not applicable
Area of cover is
worldwide

26 Health management services

Access to our CARE team to receive tailored information and discuss any chronic condition and disease management.

✓
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.

✓
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.

✓
Included

***i** We'll cover a maximum of five counselling session 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.

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.

Included

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