



International Healthcare Plan

Benefits Schedule

\$ - Essential

Effective 1 April, 2012

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

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

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

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

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

	Essential
Maximum Annual Aggregate Limit	A maximum of \$1,600,000 per member per period of cover
Inpatient, Day Patient, Emergency Care and Diagnostics	
Inpatient Care Reconstructive Surgery and Rehabilitation	Covered in full i) Accommodation is subject to any selected inpatient bed limit ii) Rehabilitation is covered in full up to 120 days per medical condition
Accident & Emergency Treatment Outside Area of Cover	Covered in full for inpatient treatment Outpatient treatment is limited to \$500 per medical condition and subject to an excess of \$80 per medical condition
CT PET and MRI Scans	Covered in full
Organ Transplant	Covered in full
Inpatient Psychiatric Treatment	Covered in full (up to 30 days) per period of cover
Accidental Damage to Teeth	Covered in full
Hospital Cash	Up to \$125 per night for a maximum of 20 nights per medical condition
Parental Accommodation	Covered in full
Disease and Chronic Conditions Management	
Oncology	Covered in full
Chronic Conditions	Up to \$5,000 per insured person per period of cover
Congenital Anomalies	Up to \$100,000 per medical condition
Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS)	Up to \$1,000 per medical condition
AIDS	Up to \$10,000 per insured person per period of cover
Hospice Care	No cover
Hormone Replacement Therapy	Covered in full up to 18 months per lifetime
Outpatient and Alternative Treatments	
Outpatient Care	Covered in full
Outpatient Surgery	Covered in full
Outpatient Psychiatric Treatment	Up to \$5,000 per period of cover
Alternative Treatment	Covered in full up to 10 sessions in aggregate per medical condition
Vaccinations and Inoculations	Up to \$100 per period of cover
Home Nursing	Covered in full up to 30 days per medical condition
Evacuation and Transportation	
Emergency Transportation	Covered in full

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

	Essential
Complications of Pregnancy – no wait period	Covered in full
Compassionate Emergency Travel	No cover
Congenital Anomalies - Including Pre-existing Congenital Anomalies	Covered in full <i>OR</i> Up to \$100,000 per medical condition <i>OR</i> Up to \$250,000 per medical condition
Dental 1 - Routine Dental Treatment	Up to \$250 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$250 per period of cover and no coinsurance <i>OR</i> Up to \$500 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$500 per period of cover and no coinsurance <i>OR</i> Up to \$750 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$750 per period of cover and no coinsurance <i>OR</i> Up to \$1,000 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$1,000 per period of cover and no coinsurance <i>OR</i> Up to \$1,500 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$2,000 per period of cover and subject to 25% cover and subject to 25% coinsurance <i>OR</i> Up to \$2,500 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$1,500 per period of cover and no coinsurance <i>OR</i> Up to \$2,000 per period of cover and no coinsurance <i>OR</i> Up to \$2,500 per period of cover and no coinsurance

	Essential
Dental 2 - Major Restorative Dental Treatment	Up to \$500 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$500 per period of cover and no coinsurance <i>OR</i> Up to \$750 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$750 per period of cover and no coinsurance <i>OR</i> Up to \$1,000 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$1,000 per period of cover and no coinsurance <i>OR</i> Up to \$1,500 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$2,000 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$2,500 per period of cover and subject to 25% coinsurance <i>OR</i> Up to \$1,500 per period of cover and no coinsurance <i>OR</i> Up to \$2,000 per period of cover and no coinsurance <i>OR</i> Up to \$2,500 per period of cover and no coinsurance
Dental 3 - Orthodontic Dental Treatment	Up to \$500 per period of cover and subject to 50% coinsurance <i>OR</i> Up to \$1000 per period of cover and subject to 50% coinsurance <i>OR</i> Up to \$1,500 per period of cover and subject to 50% coinsurance <i>OR</i> Up to \$1,500 per period of cover and no coinsurance <i>OR</i> Up to \$500 per period of cover and no coinsurance <i>OR</i> Up to \$1000 per period of cover and no coinsurance

	Essential
Dental 5 - Combined Routine & Restorative Dental	Up to \$1,500 per period of cover and no coinsurance <i>OR</i> Up to \$1,500 per period of cover and subject to 25% coinsurance
Dental 6 - Combined Routine & Restorative Dental with Orthodontics	Up to \$2,500 per period of cover and no coinsurance <i>OR</i> Up to \$2,500 per period of cover and subject to 25% coinsurance
Dental 7 - Combined Routine & Restorative Dental with Orthodontics and Dental Implants	Up to \$3,000 per period of cover and no coinsurance <i>OR</i> Up to \$3,000 per period of cover and subject to 25% coinsurance
Outpatient Direct Settlement Network - nil excess This benefit is available where a Nil, \$50 <i>OR</i> \$100 policy excess has been selected.	Outpatient consultations are available on a nil excess basis where treatment is received in network. Where outpatient consultations take place outside the direct settlement network the policy excess applies.
Extended Evacuation (to the country of choice)	Covered in full
Out of Country Transportation For medically necessary non-emergency treatment as an inpatient or day patient i) Travel ii) Non- hospital accommodation	i) Covered in full ii) Up to \$150 per person per day and \$5,000 per person, per evacuation <i>OR</i> Up to \$250 per person per day and \$10,000 per person, per evacuation
Infertility Treatment (minimum of 10 Employees required)	No cover
Routine Pregnancy	Up to \$5,000 or per pregnancy and subject to 20% coinsurance <i>OR</i> Up to \$5,000 per pregnancy and no coinsurance <i>OR</i> Up to \$10,000 per pregnancy and subject to 20% coinsurance <i>OR</i> Up to \$10,000 per pregnancy and no coinsurance <i>OR</i> Up to \$20,000 per pregnancy and subject to 20% coinsurance per pregnancy <i>OR</i> Up to \$20,000 per pregnancy and no coinsurance <i>OR</i> Covered in full per pregnancy but subject to 20% coinsurance <i>OR</i> Covered in full per pregnancy with no coinsurance

	Essential
Traditional Chinese or Ayurvedic Medicine	\$30 per session to a maximum of 10 sessions <i>OR</i> \$30 per session to a maximum of 20 sessions <i>OR</i> £30 or €35 or \$50 per session to a maximum of 30 sessions <i>OR</i> Up to \$500 per period of cover <i>OR</i> Up to \$750 per period of cover
USA Elective Treatment i) Inpatient or day patient treatment received inside the direct settlement network ii) Inpatient or day patient treatment received outside the direct settlement network iii) Outpatient treatment The International Healthcare Plan (IHP) does not comply with the Patient Protection and Affordable Care Act (U.S. healthcare reform), and cannot be used to satisfy any requirements for health insurance cover mandated therein.	i) Covered in full ii) Up to \$1,000,000 per member per period of cover and subject to 50% coinsurance iii) Covered in full
Vision Care	One eye exam and a maximum benefit of up to \$250 per period of cover <i>OR</i> One eye exam and a maximum benefit of \$500 per period of cover <i>OR</i> One eye exam and a maximum benefit of \$750 per period of cover
Wellness Option 1 Routine medical checkups & well-baby checks	Up to £160 or €200 or \$250 per insured person per period of cover
Wellness Option 2 Bilateral mammogram/breast examination and routine gynaecological tests including PAP tests Testicular/prostate examination/PSA/DRE tests Routine medical checkups Well-baby checks	Up to \$500 per insured person per period of cover <i>OR</i> Up to \$750 per insured person per period of cover <i>OR</i> Up to \$1,000 per insured person per period of cover <i>OR</i> Up to \$1,500 per insured person per period of cover
Wellness Option 3 Preventive Screening Preventive screening for members who are deemed at high risk	Up to \$1,000 per insured person per period of cover <i>OR</i> Up to \$1,500 per insured person per period of cover



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