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Aetna SummitSM

USD

Benefits Schedule for RMIT University Vietnam LLC (Student)

For plans starting on or after 1 November 2019



At a glance



Overall plan limit

as shown on your **Certificate of Insurance**



Annual excess

This is the total excess each **member** needs to pay towards **claims** in the **plan year**, as shown on your **Certificate of Insurance**.



Outpatient coinsurance

This is the percentage of coinsurance each **member** needs to pay towards **claims** in the **plan year** 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 Aetna 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 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 Aetna 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
- ⑱ Dental treatment
- ⑳ Optical care
- ㉑ Wellness
- ㉒ Pregnancy and Childbirth
- 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 ⑱ [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. The **benefits** detailed below are available within your chosen **tier** and **Area of Cover**:

Aetna SummitSM 2500

Category Description	All Employees
Area of Cover	Coverage Area 2
Provider Access	Not Applicable
Underwriting Type	MHD

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**.

\$500,000

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.

Not applicable

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 In-patient 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 pregnancy was the result of 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

Paid up to a lifetime limit of
\$150,000

Not covered

Not applicable

3 Parent accommodation

Hospital accommodation costs for a parent or legal guardian to stay with the **member** if **they're** aged 17 or under and receiving **inpatient treatment** that **we** cover under **2** [Inpatient and daycare treatment](#).

Hospital accommodation costs for a companion to stay with the **member** if **they're** aged 18 or over, their condition is **critical** and **they're** receiving **inpatient treatment** that **we** cover.

Paid in full

Not applicable

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**.

\$15 per consult

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**.

Paid in full for up to 60 days following each admission

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**.

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

\$15 per consult

6 Cancer care

All **treatment** for, or related to, a diagnosed cancer. This includes **palliative treatment** and care.

Paid in full

i **Annual excess**

Not applicable

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 .	
Medical practitioners' and specialists' fees, prescribed drugs and dressings, MRI scans, X-rays, pathology and diagnostic tests and procedures .	Paid up to \$5,000
Outpatient treatment for medical conditions that that are an emergency when the treatment is received in a hospital .	
Kidney dialysis.	
PET and CT scans.	Paid in full
i Your outpatient coinsurance applies, as shown on your Certificate of Insurance .	\$15 per consult

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.	
Outpatient physiotherapy when a medical practitioner or specialist refers you.	Paid up to \$3,000
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.	
Outpatient podiatry, osteopathic and chiropractic treatment when a medical practitioner or specialist refers you.	
Outpatient traditional Chinese medicine, ayurvedic medicine, acupuncture and homeopathic treatment .	Paid up to \$300
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 .	\$15 per consult

9 Psychiatric treatment

Up to 30 days inpatient psychiatric treatment and psychotherapy in the plan year .	Paid in full
i Outpatient coinsurance doesn't apply	
Outpatient psychiatric treatment and psychotherapy.	Not covered
Inpatient and outpatient psychiatric treatment and psychotherapy when your medical condition is an emergency .	Not applicable
i Your outpatient coinsurance applies, as shown on your Certificate of Insurance .	Not applicable

10 Durable medical equipment

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.

Not covered

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
- 26 Emergency treatment outside your area of cover

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

Not applicable

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**.

Not covered

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

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.

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.

Not Applicable

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

Not applicable

12 HIV or AIDS

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

Not covered

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

Not applicable

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**.

\$15 per consult

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

Paid in full

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

\$15 per consult

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**.

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

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 **emergency** medical evacuation that **we** cover. 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.

Paid up to \$2,000

The costs to transport **you** to appropriate medical facilities for **treatment** related to your pregnancy if its 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 **22** [Pregnancy and childbirth](#) and you have completed any waiting periods shown in section **22**.

Not covered

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

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 **you're** burial, **we'll** cover:

- The cost of opening or reopening a grave
- Any exclusive right of burial fee
- Burial costs

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

- The cost of any doctor's certificates
- Cremation costs, including the removal of any medical device before the 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**.

Not covered

19 Dental Treatment

<p>Outpatient dental treatment for damage to natural teeth caused by an accident when:</p> <ul style="list-style-type: none"> • your dental condition is not an emergency • 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. <p>This benefit includes the cost to supply and fit dental implants.</p>	Paid in full
<p>Outpatient dental treatment for damage to natural teeth caused by an accident, except when the damage is caused by eating. Cover is only available when your dental condition is not an emergency and 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.</p>	Paid up to \$500
<p>i Your annual excess applies, as shown on your Certificate of Insurance.</p>	Not applicable
<p>i Your outpatient coinsurance applies, as shown on your Certificate of Insurance.</p>	\$15 per consult
<p>Outpatient dental treatment when your dental condition is an emergency.</p>	Not applicable
<p>Emergency dental coinsurance</p>	Not applicable
<p>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, minor gum treatment, X-rays, composite fillings and simple non-surgical extractions only.</p> <p>Cover is available after you've had 182 days' continuous cover from the date that this optional benefit was first included in your plan. This waiting period is waived for MHD.</p>	
<p>Major restorative dental treatment, including treatment for accidental damage to natural teeth when the damage is caused by eating. This benefit covers:</p> <ul style="list-style-type: none"> • 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 • Major gum treatment <p>Cover is available after you've had 182 days' continuous cover from the date that this optional benefit was first included in your plan. This waiting period is waived for MHD.</p>	Not covered
<p>Dental coinsurance</p>	Not applicable

19 Dental Treatment Continued

<p>Orthodontic treatment including:</p> <ul style="list-style-type: none"> • 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
<p>Orthodontic coinsurance</p>	Not applicable
<p>Dental implants including:</p> <ul style="list-style-type: none"> • 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
<p>Dental implants coinsurance</p>	Not applicable
<p>i Annual excess</p>	Not applicable

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.

Vision aids, vision correction by surgery and hearing aids, when **treatment** is needed for a **medical condition** that is an **emergency**.

Not applicable

i Annual excess

Not applicable

Optical 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 \$250

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

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

Not covered

22 Pregnancy and childbirth

For natural and assisted conception pregnancies

• 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**:

Not covered

- 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 within the **benefit** limit shown.

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

Paid up to \$5,000

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 within the **benefit** limit shown.

Maternity coinsurance	Not applicable
<p>Treatment for medical maternity complications during pregnancy or childbirth, if the pregnancy is the result of natural conception.</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>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 within the benefit limit shown.</p>	Paid in full
<p>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 . This waiting period is waived for MHD.</p>	
<p>i These benefits within this section do not extend to 3D or 4D ultrasound scans.</p>	
<p>i Annual excess</p>	Not applicable

23 Hormone replacement therapy

Hormone replacement therapy for symptoms of the menopause.	Not covered
<p>i Your outpatient coinsurance applies, as shown on your Certificate of Insurance .</p>	Not applicable

24 Hospital Cash

We'll pay you for each night you stay in a hospital for inpatient treatment:	
<ul style="list-style-type: none"> • 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. <p>We'll pay for a maximum of 20 nights in the plan year.</p>	Paid up to \$125
<p>i Annual excess</p>	Not applicable

25 Emergency treatment outside area of cover

Inpatient and daycare treatment when your medical condition is an emergency .	Paid in full
<p>i Outpatient coinsurance doesn't apply</p>	
Outpatient treatment when your medical condition is an emergency .	Paid up to \$500
<p>i Your outpatient coinsurance applies, as shown on your Certificate of Insurance .</p>	\$15 per consult

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** .

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.

Paid up to \$500

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.

Not Included

i We'll cover a combined 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

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

28 Outpatient direct billing

Direct billing helps cut out-of-pocket costs at the point of service

If selected, outpatient costs for the following treatments can be settled directly with the provider:

- 4 Outpatient post-hospitalisation treatment
- 5 Rehabilitation
- 6 Cancer care
- 7 Outpatient treatment
- 11 Congenital abnormalities
- 22 Pregnancy and childbirth

Included

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