Aetna Summit℠ Handbook

Aviation Professionals Club

The details

For plans starting on or after
28 June 2022

Visit **aetnainternational.com**
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In association with: AES HEALTH

What's inside?

Before you join us

While you're with us

The extra bits

What to do right now

Your benefits are designed to connect you with expansive global resources that put you in control of your health.

It starts with choice, comfort, care and an unwavering commitment to keep you at the centre of everything we do.

Get connected

Secure Member Website

Now is a good time to register for the Secure Member Website. The site gives you the tools you'll need to manage your health benefits. You can register in just a few steps by visiting **www.aetnainternational.com** and clicking "*Secure login*" under the "*Aetna Member*" section. You'll need to enter your name, date of birth and Medical ID card number.

Note that all members 18 years and over need to be registered in order to submit their claims online.

You can use the website to:

- Submit and track claims
- Find nearby doctors and hospitals
- Browse a library of health topics
- View your plan documents

International Mobile Assistant

If you have a smartphone, you can also download helpful apps, such as our International Mobile Assistant, which makes it easy to manage your benefits on the go. You can search "Aetna" in the iTunes or Google Play store to get started.

Get support for balanced living

Staying on top of the demands of work, family and finances can be challenging. It's important to recognise when situations create an unhealthy amount of stress. Before any work or life issue becomes a larger problem, you can turn to our Employee (Member) Assistance Programme for help.

This programme gives you access to confidential counselling with behavioral health experts in over 200 countries. We've designed this programme to support what matters most to us – your total well-being.

Get ready for your next doctor visit

You may need to obtain prior approval (preauthorisation) for certain types of treatment. In these instances, it's important to start the process early to prevent delays or denial of your claims.

Here are some of the treatments that require preauthorisation:

- Medical evacuation
- Inpatient or daycare treatment admission
- Compassionate emergency visit
- Preparation or transportation of body or mortal remains
- Psychiatric treatment
- Single treatment or service that costs more than USD 500 or equivalent

All preauthorisations must be requested before treatment or services are received or costs are incurred. Please refer to page 22 for more details – If it is not possible to request preauthorisation for an emergency, please be sure to notify us within the first 24 hours.

You can find full details in your Claims procedures or in the Claims Centre of the Secure Member Website.

Your Medical ID card

The Medical ID card is your key to quality health care. Make sure to keep the card in a safe place – you'll be asked to present it whenever you receive health care treatment. You may also need to have it handy when registering for the Secure Member Website or calling Member Services.

Before you join us

1 Introduction

This Handbook, together with your Benefits schedule found on page 6, explains what is, and is not, covered under the Summit plan.

For information on how to make a claim please refer to **your Claims procedures** found on page 21.

If you have any questions about the information in the **plan documentation** or any questions you think it does not answer, please contact **us** and **we** will be more than happy to help.

Some words and phrases used in this Handbook, **your Benefits schedule** and **your Claims procedures** have specific meanings. **We** have highlighted them in bold print and defined them in the "Definitions" section of this Handbook.

A **plan** is **our** contract of insurance with the **plan**holder, providing cover as detailed in the **plan documentation**. In order to fully understand a **plan**, these documents must be read together.

2 About the plan

We can change any of the following at the beginning of each **plan year**:

- Conditions, exclusions and any other terms in this Handbook
- Premiums and any discounts or surcharges

We will tell the **plan sponsor** about any changes before the **plan renewal date**.

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

Member eligibility

The Summit **plans** and **add-on plans** are available to people of most nationalities. **We** cannot cover people subject to sanctions. **Our plans** are not available to citizens of the U.S. who reside in the U.S. Please contact **us** if you need further information. **Plans** may not meet specific visa requirements. Cover may also be illegal under local laws. It is **your** responsibility to ensure that any **plans** chosen meet **your** needs.

You must have continuous Aetna membership under the Summit **plan** and any **add-on plans**.

All **dependent** children on a **plan** must be unmarried. Children can remain on the **policy** as long as there is a parent on the scheme as a main member, only children up to the age of 26 will be allowed to join the scheme.

Members aged 58 or above are not entitled to enter the medical scheme.

You must have an Aviation Professionals Club (APC) membership for the entire plan year. APC have the right to cancel your plan without a refund if your membership of the APC is not valid or maintained.

Plan benefits and currency

The **plan sponsor** has chosen the **plan** level and **benefits**, including any **add-on plans** that are available to you. Summit **plans** and any **add-on plans** are provided on the basis of an employer-paid annual contract only.

The **plan sponsor** has chosen the currency of **your** Summit **plan** from the currencies available. They chose this at application or renewal and it will apply throughout the entire **plan year**. Any **add-on plans** that have been chosen are in the same currency as the Summit **plan**.

If more than one currency is shown on **your Benefits schedule**, the benefit limit shown in the same currency as the **plan** will apply to you.

Clinical Policy Bulletins

We have developed Clinical Policy Bulletins (CPBs) to assist in administering **our plans**. CPBs express **our** determination of whether certain **treatment**s, services or costs are **medically necessary**, unproven, experimental, investigational or cosmetic. They are based on objective and credible sources, including scientific literature, guidelines, consensus statements and expert opinions. You can find **our** Medical, **Dental** and Pharmacy CPBs at **www.aetna.com/health-care-professionals/clinical-policy-bulletins.html**.

CPBs are not a description of cover. The conclusion that a particular **treatment**, service or cost is **medically necessary** does not confirm that this **treatment**, service or cost is covered under the **plan**. This Handbook, together with the **Benefits schedule** and **Certificate of insurance**, explains what is, and is not, covered under the **plan**. The **plan** may exclude coverage for **treatment**s, services or costs that are determined as **medically necessary** within a CPB. If there is a discrepancy between a CPB and the **plan**, the terms of the **plan** will apply.

CPBs can be highly technical. You should talk about the information in them with **your medical professional** if you need to understand how they apply to you.

3 Summary of benefits

To find out about the key features of the Summit Plan, please see the following **benefits** schedule.

The words and phrases that are in bold have specific meanings, and are defined in this **member** handbook.

This will be a 12-month policy starting from the date of entry or any subsequent renewal date, as applicable. It is the responsibility of the policyholder to continually review **your** policy in order to ensure that the **plan** selected continues to meet the needs and requirements of Aviation Professionals Club (APC) **members**.

The policy provides cover for **treatment** as a secondary cover to **your** employer's **plan**/local **plan**. All claims must be supported by documentation from **your** employer/ local **plan** provider evidencing that either **your** diagnosis is not covered or that **your plan** benefit limits have been exceeded.

You must claim from **your** employer's scheme before making a claim with **us**.

Pre-existing conditions have a one-year waiting period applied for all new entrants to the medical scheme if they are existing APC **members**. This is to protect the insured population from **members** joining only when they develop major **medical conditions**. The waiting period will apply from the date of joining the scheme.

This **plan** is not DHA-compliant and will only serve as a top-up to an employer's DHA-compliant cover whilst you are a Dubai resident. If you do not have a primary DHA **plan** in place in Dubai then this cover will not be applicable.

We'll only pay reasonable costs for claims. 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 and experience. For more details refer to sections C15 & C16 or contact your broker.

At a glance

Overall plan limit Up to 4,000,000 USD

Outpatient coinsurance No outpatient coinsurance

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**.

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.

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**.	**4,000,000 USD**

2 Inpatient and daycare treatment
For acute medical conditions and stabilisation of acute episodes of chronic medical conditions

Medical costs including intensive care, theatre, **hospital** accommodation, **medical practitioners, specialists**, anaesthetists, nursing, **appliances** and prescribed drugs and dressings.	✔ 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. 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.	✔ Up to a **lifetime limit** of 100,000 USD

3 Parent accommodation

Hospital accommodation costs for a parent or legal guardian to stay with the **member** if they are aged 17 or under and receiving **inpatient treatment** that **we** cover under section 2 Inpatient and daycare treatment.	✔ Paid in full

4 Outpatient post-hospitalisation treatment
For acute medical conditions

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 up to 3,000 USD in aggregate to cover under sections 7 & 8

5 Rehabilitation
For acute medical conditions and stabilisation of acute episodes of chronic medical conditions

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 section 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 section 8 Physiotherapy and complementary medicine.*

✔ Paid in full for up to 120 days after **you**'re discharged or transferred

6 Cancer care

All **treatment** for, or related to, a diagnosed cancer. This includes **palliative treatment** and care during the end stages of a cancer.

✔ Paid in full

7 Outpatient treatment
For acute medical conditions

Surgical procedures.	✔ Paid in full
Medical practitioners' and **specialists**' fees, prescribed drugs and dressings, PET, CT and MRI scans, X-rays, pathology and **diagnostic tests and procedures** prior to hospitalisation up to 72 hours before **inpatient** or **daycare treatment**.	Paid up to 3,000 USD in aggregate to cover under sections 4 & 8

8 Physiotherapy and complementary medicine
For acute medical conditions

Physiotherapy as part of **inpatient** or **daycare treatment**. *i Outpatient coinsurance doesn't apply.*	✔ Paid in full
Post-hospitalisation outpatient physiotherapy after each **inpatient** or **daycare** admission, on referral by a **medical practitioner** or **specialist** is restricted to 10 sessions per **medical condition**. *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 up to 3,000 USD in aggregate to cover under sections 4 & 7 and 8
Outpatient physiotherapy when a **medical practitioner** or **specialist** refers **you**.	Paid for up to 5 sessions per plan year
Outpatient podiatry, acupuncture, osteopathic homeopathic and chiropractic **treatment**, when referred by a **medical practitioner** or **specialist**. Further medical information may be needed if **you** receive further treatment after you have completed the number of sessions that were referred by the **medical practitioner** or **specialist**.	Paid for up to 10 sessions in aggregate per **medical condition** and paid up to 3,000 USD in aggregate to cover under sections 4, 7 and 8

⑧ Physiotherapy and complementary medicine Continued
For acute medical conditions

*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**.*

9 Mental health
For acute medical conditions

Up to 30 days **inpatient** psychiatric **treatment** and psychotherapy in the **plan year**.

✔ Paid in full

Aetna Mind – Provides **you** with tools for better mental health:

- Discover self-help solutions that develop positive mental health through educational well-being articles and how-to guides
- Receive direction and assistance with access to a range of evidence-based well-being tools for issues such as depression, anxiety, stress, substance abuse, chronic pain and sleep disturbance
- Access guided support from diagnosis to condition management.

Log in to your Health Hub Well-being section to find out how to access these services.

www.aetnainternational.com/members/login.do

Employee Assistance Programme – Includes 24/7 real-time confidential support, as well as up to five in-person, telephonic or video counselling sessions annually for each work, personal or family issue.

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, personal protective equipment, furniture or any modifications to your personal or work environment.

✔ Paid up to 1,000 USD per **medical condition**

*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*
- *22 Pregnancy and childbirth*
- *25 Emergency treatment outside your area of cover*

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

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

12 HIV or AIDS

All **treatment**, including **palliative treatment** and care, for diagnosed HIV or AIDS and all **related medical conditions**.	✔ Paid up to 10,000 USD

13 Organ transplants
For acute and chronic medical conditions

Kidney, pancreas, liver, heart or lung transplants and any related **treatment**.	✔ Paid in full

14 Terminal care

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*	✔ Paid in full

15 Medical evacuation

The costs to transport **you** to the nearest appropriate medical facility when **we** agree that your **medical condition** is an **emergency** following an assessment by a **medical practitioner** in a local medical facility, and that **treatment** is not available locally in any public or private medical facility. 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** evacuation that was covered under this **plan**. If **we** agree that **you**'re not medically fit to travel following your **treatment**, this **benefit** extends to reasonable overnight accommodation costs including breakfast until **you**'re fit to travel.	✔ Paid in full
Costs of: • one companion to accompany **you**, or travel at the same time if they're not able to accompany **you** during your **emergency** evacuation, if your **medical condition** is critical or **you**'re expected to stay in **hospital** for seven or more nights; or • one companion or non-medical escort needed to assist **you** during your **emergency** evacuation if your **medical condition** prevents **you** from travelling alone, **you** do not need a medical escort, your **medical condition** is not critical and **you**'re not expected to stay in **hospital** for seven or more nights. We'll cover costs for: • One return economy class journey, including taxi transfers to and from their hotel on arrival and departure • A taxi from their hotel to the **hospital**, and back, once a day for the duration of your evacuation • Their reasonable overnight accommodation costs including breakfast for the duration of your evacuation, until **you**'re ft to travel back to your **country of residence** or **home country**.	✔ 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 in any public or private medical facility, and • **we** agree appropriate **treatment** is available in your chosen location. **We**'ll also cover costs for: • Taxi transfers to and from the hotel on arrival and departure • A taxi from the hotel to the **hospital**, and back, once a day for the duration of your evacuation • Reasonable overnight accommodation costs including breakfast for the duration of your evacuation, until **you**'re fit to travel back to your point of departure This **benefit** also extends to these travel and accommodation costs for a companion or non-medical escort to accompany **you**, if your **medical condition** prevents **you** from travelling alone and you do not need a medical escort. The cost of their return economy class travel will only be covered from your point of departure. Cover is only available under this **benefit** if the **treatment** is covered under 2 Inpatient or daycare treatment, or 4 Outpatient post-hospitalisation treatment.	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 in any public or private medical facility, 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**. *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 *Mental health* 11 *Congenital abnormalities* 12 *HIV or AIDS* 13 *Organ transplants* 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 return travel 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 up to 2,000 USD

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.

✔ 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**.

✔ Paid in full

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

Optical **coinsurance** — Not applicable

21 Wellness

Vaccinations.	✓ Paid up to 600 USD
Routine health checks for **non-communicable diseases**. This includes cancer screening, cardiovascular examinations, neurological examinations and vital sign tests. This benefit extends to an **annual health assessment** excludes mammogram (refer to below section), **Members** can avail this **benefit** on direct settlement agreement with UPANDRUNNING and Valiant Medical Center (packages are worth 1,000 USD). Otherwise it is on a reimbursement basis.	
Routine Mammogram – One Mammogram screening in the plan year for women ages 40 years old and above. Direct Billing only available at Healthbay Polyclinics, Sharjah Corniche Hospital and Doctors Medical Center. Otherwise it is on a reimbursement basis.	✓ Paid up to 200 USD
Outpatient tests and diagnostic procedures for **communicable diseases** when **you** do not have signs or symptoms, and they are not received in relation to a diagnosed **medical condition**. This benefit extends to **outpatient** antibody tests.	Not covered
One sight examination in the **plan year**.	✓ Paid up to 50 USD

22 Pregnancy and childbirth

Treatment for medical maternity complications that happen due to a **medical condition** 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	✓ Paid in full

23 Hormone replacement therapy

Hormone replacement therapy for symptoms of the menopause.	✓ Paid up to 500 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.*	✔ Paid in full
Outpatient treatment when your **medical condition** is an **emergency**.	✔ Paid up to 1,500 USD per **medical condition**
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
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.	✔ Included

27 Aetna security assistance

24/7 personal security information and telephone support for all your travel safety queries. Log in to your Health Hub to find out more and to register for this service.	✔ Included

28 Developmental disorders of the brain

All investigations for developmental disorders of the brain is covered up to the point of diagnosis only and not **treatment**.	✔ Paid up to 750 USD

4 Plan conditions and exclusions

Material facts

C1 The **plan administrator** must tell **us** all **material facts** before **we** accept an application, make changes to a **plan** or renew a **plan**. The **plan administrator** must check that any **material facts** are correct. You must check that any **material facts** about you are correct. If there is any doubt about whether a fact is material, for **your** own protection, the **plan administrator** should tell **us**. Where applicable the 12-month **moratorium** will still apply even if the **plan administrator** tells **us** about any **pre-existing medical conditions** you may have.

If **we** find out that the **plan administrator** has not told **us** about all **material facts we** can cancel the **plan** or apply different terms to the **plan**.

C2 The **plan administrator** must tell us immediately in writing about any change that affects information given in connection with the application for a **plan**, including information about you.

After **we** have been told about a change:

- **We** have the right to reassess **your** cover if it is a change to important information about you. **We** may apply new terms to you, or cancel **your** cover
- **We** have the right to reassess the **plan** if the change to important information is about the **plan sponsor** or affects all or part of the **plan**. **We** may apply new terms to the **plan**, or cancel the **plan**

If there is a change in risk that the **plan administrator** has not told **us** about, **your** cover may be cancelled, the **plan** may be cancelled, or any related claim may be reduced or rejected.

C3 By becoming a **member** of the scheme, **you** are aware that the **plan** does not meet DHA requirements and **you** must maintain DHA compliant cover whilst being a UAE resident. This applies to the **member** and any **dependants** covered on the scheme.

C4 **Members** of the scheme may be asked to provide proof that DHA compliant cover is in place at the time of application and thereafter at renewal.

C5 The APC reserves the right to require an applicant and dependants to complete additional application forms before being accepted on the scheme.

C6 The member is entitled to maintain the policy after leaving the UAE, subject to retaining the APC Membership and being a member of the scheme for two consecutive years. Coverage outside the UAE will be provided by Aetna Life & Casualty (Bermuda) Limited or any other Aetna entity.

C7 All dependant children included in the plan must have a main member on the APC scheme.

Preauthorisation and timely claim filing

C8 If a benefit needs **preauthorisation** as shown on **your Benefits schedule**, you or **your** personal representative must request **preauthorisation** before **treatment** or services are received or costs are incurred. Once you or **your** personal representative have received **our** approval, **we** will settle all covered costs directly with the providers. If you or **your** personal representative do not receive **our** approval before costs are incurred, **we** will only approve the costs **we** would have paid if **we** had been involved and given **our** approval.

C9 You or **your** personal representative should tell **us** about a claim no later than 180 days after the date of **treatment** or services received, if it relates to **your** Summit medical **plan.** If a claim is not received within the period shown, **we** reserve the right to reject such claim subject to the applicable laws.

Treatment provision and referral

C10 All **treatment** must be given with the aim to cure or substantially relieve **medical conditions**.

C11 Treatment must be given by **medical practitioners**, **specialists**, **nurses** or **therapists**. All psychiatric **treatment** and psychotherapy must be given by **medical practitioners**, psychiatrists or qualified and registered psycho**therapists** or psychoanalysts.

C12 If **your medical practitioner** or **specialist** refers you for further **diagnostic tests and procedures** or **treatment**, **we** may not pay **your** claim if you do not undergo the **diagnostic tests and procedures**, or start **treatment**, within 90 days of the referral date.

C13 Physiotherapy, podiatry, osteopathic and chiropractic **treatment** must be referred by a **medical practitioner** or **specialist**.

Innocent bystanders

C14 Where a benefit is available on **your plan**, **we** will cover costs arising from or connected with:

- **conflict or civil unrest** if, in **our** reasonable opinion:
  - you are not actively participating,
  - you are not a **member** of any armed force or security service, including personal protection,
  - you have not knowingly entered or remained in a location where there is **conflict or civil unrest**, and
  - you have not intentionally put **yourself** at risk of injury.
- a natural disaster if, in **our** reasonable opinion:
  - you have not knowingly entered or remained in a location where there is a natural disaster, and
  - you have not intentionally put **yourself** at risk of injury.
- contamination or injury from any biological, chemical or nuclear materials, including combustion of nuclear fuel if, in **our** reasonable opinion:
  - you have not knowingly entered or remained in a location where there is contamination,
  - you are not a **member** of a biological, chemical or nuclear contamination cleaning crew of any kind, and
  - you do not intentionally put **yourself** at risk of contamination or injury.

Reasonable costs

C15 Only reasonable costs will be paid for claims. Reasonable costs are the average cost of **treatment**, expertise or services given by similar types of provider:

within the same country or geographical region, and

based on **our** knowledge and experience.

C16 If a **visiting doctor** instead of an **in-house doctor** treats you, in a **hospital**, clinic or any other facility where **direct billing** or cashless arrangements are in place, only reasonable costs will be paid. You will have to pay the difference if the **visiting doctor**'s costs are not reasonable and not in line with the **in-house doctor**'s costs.

Ineligible claims

C17 If you attend a **hospital**, clinic or any other facility where **direct billing** or cashless arrangements are in place, and **we** subsequently determine that **your** claim is an **ineligible** claim, **we** have the right to recover the full amount of the claim. Payment of any claim is not an indication of **our** acceptance of liability for the claim or confirmation that further costs for the same **medical condition** or any **related medical condition** will be met.

C18 If **we** receive new information that shows a claim **we** have already approved is **ineligible**, no costs will be paid. If any costs have already been paid, **we** will recover the costs and no further costs will be paid. Any approval **we** have given during the **preauthorisation** process may also be withdrawn. After **we** have given notice that you must repay any costs, this must be done within 14 days, failing which, **we** reserve the right to cancel the **plan**, subject to applicable laws.

C19 If you would like **us** to re-assess a claim **we** have rejected under a **plan** for any reason, you will have to prove that the claim is covered under the **plan**.

Exclusions

The Summit **plan** does not cover claims for, arising from or connected with the following exclusions unless shown on **your Benefits schedule**, or agreed by **us** in writing.

Underwriting terms

E1 This exclusion applies if **your** underwriting terms are **moratorium** or **CTT previously moratorium**, as shown on **your Certificate of insurance**. Exclusion E1 do not apply if **your** underwriting terms are MHD.

A **pre-existing medical condition** or **related medical condition** that, within a 12-month period before the **date of joining** or the date shown on the special terms section of **your Certificate of insurance**, has one or more of the following characteristics:.

- Was foreseeable
- Clearly showed itself
- You had signs or symptoms of
- You asked for **advice** about
- You received **treatment** for
- To the best of **your** knowledge, you were aware you had

Pre-existing medical conditions or **related medical conditions** may be covered after you have had 12 months' continuous cover under the **plan**.

Plan and benefit availability and limitations

E2 Costs incurred:

- That exceed a limit shown on **your Benefits schedule**
- If you have not completed the waiting period shown on **your Benefits schedule**
- If these are less than the value of any **deductible** that applies to **your plan**
- If no relevant benefit is included on **your plan**
- For a benefit not covered on **your plan**, even if cover was included in any previous **plan year**
- That may be associated with a claim, but are not covered under **your plan**. For example, loss of earnings as a result of a **medical condition**
- Elective Treatment outside your area of cover (Emergency treatment is covered)

E3 Costs incurred for, or in relation to, any portion of **treatment** or services received before **your start date** or after **your end date**.

E4 Medical evacuations if a local situation makes it impossible, dangerous or not practical to enter a specific location or country.

False and fraudulent claims

E5 A false or fraudulent act you know about. If **we** have paid any part of the claim, **we** will recover the costs.

Treatment provision and referral

E6 **Treatment** that **we** determine on **general advice** is unproven, experimental or investigational.

E7 Drugs or dressings that:

- are not recognised by the pharmaceutical regulator in the country where **treatment** is provided,
- are obtained without prescription, or
- are prescribed for a **medical condition** that is different to the one that is being claimed for.

E8 Dietary supplements, substances and personal products, including, but not limited to, vitamins, minerals, mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, children's food, baby supplies and infant formula given orally.

E9 Home visits by a **medical professional**, unless specifically agreed by **us** prior to consultation.

E10 **Treatment** in a spa, hydro spa, health farm or similar facility, and **treatment** given at a nursing home, similar establishment or **hospital**, where the facility has become **your** home or permanent abode or where admission is arranged partly or entirely for domestic reasons.

E11 **Treatment** given, or referrals made by, a **medical professional** or **dental** practitioner who is **your** spouse, **partner**, child, parent or sibling, and self-prescribed **treatment** or self-referral if you are a **medical professional** or **dental** practitioner.

E12 Health education programmes and services, including, but not limited to, family planning, antenatal classes and parenting classes.

Administrative costs, fees and charges

E13 Costs of:

- Completing Claim forms
- Completing or obtaining any other documents
- Hospital administration fees
- Any registration fees

E14 Charges incurred for the overdue payment of any invoice.

Cosmetic

E15 Cosmetic treatment

Weight management

E16 Any treatment for weight loss or weight problems, including, but not limited to, bariatric procedures, diet pills or supplements, health club memberships, diet programmes and residential eating disorder programmes.

Reproduction and newborns

E17 Costs of:

- Contraception or sterilisation
- Treatment for sexual problems, including impotence, whatever the cause
- Fertility or infertility tests or treatment
- Assisted reproduction
- Surrogacy

E18 Pregnancy, childbirth and postnatal costs, whether complicated or not, including termination of pregnancy.

E19 Any inpatient treatment needed for an acute medical condition that begins before an insured member is eight days old if the mother's pregnancy was the result of assisted conception.

Sleep

E20 Sleep apnoea, sleep-related breathing disorders, snoring and insomnia.

Sight, hearing and dental

E21 Myopia, hypermetropia, astigmatism, natural or non-medical degenerative sight or hearing disorders, aids to help with sight or hearing, contact lens solutions, eye drops, sunglasses and prescription sunglasses.

E22 Orthodontic treatment and dental implants.

Brain and learning disorders, and speech and voice problems

E23 Developmental disorders of the brain, learning disorders, learning difficulties, speech problems and voice problem, except as covered under benefit 28.

Harvesting, storage and organ transplants

E24 The harvesting or storage of umbilical-cord blood stem cells, sperm, mature oocytes and embryos.

E25 Costs of:

- locating a replacement organ,
- removing an organ from a donor,
- transporting an organ, and
- any associated administration.

Addictions and abuse

E26 Treatment for alcohol, drug or substance abuse or any kind of addictive condition, and any injury or illness arising directly or indirectly from such abuse or addiction. Drug abuse is the use of any drug:

- in a manner or in quantities other than as directed or prescribed on medical authority, or
- for any reason other than that for which it was originally prescribed.

Gender reassignment

E27 Treatment directly or indirectly associated with gender reassignment.

Journeys and transportation

E28 Any journey made specifically for the purpose of receiving treatment, unless you have requested preauthorisation and we have given our approval.

E29 Non-emergency transportation.

Acting against medical advice

E30 Any journey, activity, action or pursuit carried out against the advice of a medical professional.

Professional sports and hazardous activities

E31 Playing professional sports, taking part in motor sports of any kind, using a weapon or firearm for any purpose, and the following hazardous activities:

- Mountaineering, potholing, spelunking and caving
- High-altitude trekking over 2,500 m
- Winter sports carried out off-piste (excluding skiing)
- Arctic or Antarctic expeditions

Self-inflicted medical conditions

E32 Suicide, attempted suicide or any deliberate, self-inflicted medical condition.

Illegal activities

E33 You acting illegally, or committing or helping to commit a criminal offence.

E34 Any inpatient, daycare or outpatient treatment in a hospital, whether planned or not:

- when received before your start date, if the treatment is still ongoing at your start date, or
- that you were aware of at your start date,

unless you or the plan sponsor told us about it before your start date and cover has been agreed by us.

5 Help us manage fraud

Fraud, let's beat it together

Fraud is a crime and healthcare fraud increases premiums for **our** customers. This is why, with **your** help, we will do **our** utmost to detect and eliminate it.

Fraud is the dishonest intent to get financial gain from, or cause a financial loss to a person or party through false representation, failing to disclose information or abuse of position.

There are many examples of fraud.

Some of these are:

- Giving false or misleading information in order to obtain insurance or a reduction in premium
- Claiming for **treatment**s or services not received
- Altering or amending invoices or any other documents
- Deliberately failing to disclose previous medical history when required
- Giving a false diagnosis
- Claiming from more than one insurer for the same **treatment** or service
- Using somebody else's insurance to obtain **treatment**s or services

We are committed to protecting you against fraud and **we** also have statutory responsibilities to prevent **our** products from being used as a vehicle for financial crime.

Maladministration, including innocent and careless overcharging for **treatment**s and services, also raises the cost of medical insurance.

Some examples of maladministration include:

- Billing twice for the same service
- Incorrect billing for **treatment**s or services
- Providing unnecessary **treatment**s or services

How you can help to protect yourself and keep premiums down

There are simple steps you can take to protect yourself. Some of these are:

- Compare invoices with **your** records. Check that the dates are correct and the **treatment**s or services were actually provided to you
- Ask questions if there is anything you are unsure of or do not understand, expect or recognise
- Keep in close contact with **us** if you have made a claim
- Let **us** know if you are concerned that **your medical practitioner** is providing **treatment** that is not necessary for you
- Carefully fill in any claim forms. Ask **us** if there is anything you are unsure of or do not understand
- Look after **your** insurance details and documentation
- Make sure you understand any documentation before you sign it
- Keep copies of any documentation and correspondence
- Report suspected fraud to **us**

We work closely with others to prevent fraud

We work with Aetna to prevent and detect fraud.

In addition to **our** strict controls to deter, prevent, detect and investigate fraud, **we** also work with other insurance providers to give you the best service **we** can. Other providers **we** work with are:

- International Insurance bodies
- International Police and Investigative agencies
- Government departments

If you suspect fraud

Please contact us at:

Fraud and Investigation e-mail:
IGUKFraudGovernance@aetna.com

Fraud and Investigation Confidential telephone line:
+44-(0)1252-896-383

While you're with us

6 Data protection

We are committed to protecting your personal data and privacy. Any personal information that we collect will be kept confidential and will be processed in accordance with relevant legislation and guidelines, and our own strict internal policy.

We will use any personal data to process your claims; administer your plan, service our relationship with you; provide you with products and services and evaluate their effectiveness; and provide you with better customer services and for statistical analysis.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may also disclose your information if we are required to do so by law enforcement or other legal agencies, or governmental or judicial bodies, or to our regulators under proper authority.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

We may, from time to time, provide you with marketing information about Aetna and our products and services and those of any associated companies which may be of interest to you. You will be given an opportunity to tell us if you do not wish to receive such information.

To help us make sure that your personal information remains accurate and up-to-date, please inform us of any changes.

You have the right to see personal information about you held by us. There may be a charge for this.

Please write to:

The Compliance Officer
Aetna Global Benefits (Middle East) LLC
28th Floor, Media One Tower Building
Dubai Media City
PO BOX 6380
Dubai
United Arab Emirates

7 Complaints procedures

We strive to give you a first-class service. However, if there is an occasion when you feel we have not done this, we want to know.

Please contact us at:

The Complaints Team
Aetna Global Benefits (Middle East) LLC
28th Floor, Media One Tower Building
Dubai Media City
P.O. Box 6380
Dubai
United Arab Emirates

E-mail: **AetnaInternationalComplaints&Appeals@aetna.com**

8 Definitions

Accident – any involuntary or unexpected event resulting in a bodily injury.

Act of terrorism – an act by any person, group or groups of people, including, but not limited to, the use or threat of force or violence, whether acting alone, on behalf of, or in conjunction with, any organisation or government. This includes, but is not limited to, acts intended to influence any government or cause fear to members of the public, whatever the reason.

Acute – a medical condition that is brief, has a definite end point, and, in our reasonable opinion, based on advice or general advice can be cured by treatment.

Acute episode – an unexpected, adverse, change to the usual state of a member's chronic medical condition, which responds to treatment that aims to return them to their state of health before the event occurred.

Add-on plan – a plan available in addition to the Summit plan, that must have the same plan start date as the Summit plan.

Advice – any consultation or information given by a medical professional.

Appliances – prostheses surgically implanted to form permanent parts of the body.

Area of cover – the geographic area of the world in which a member's plan applies. This is shown on their Certificate of insurance.

Benefit – cover provided by a plan, and any extensions or restrictions shown in the Handbook, Certificate of insurance or Benefits schedule.

Benefits schedule – the document that details the benefits available under a plan.

Bodily injury – any physical harm to a member.

Certificate of insurance – a document that provides plan details, including dates of cover, member information and any special terms that may apply.

Chronic – a medical condition that has at least one of the following characteristics:

- Continues indefinitely and has no known cure
- Comes back or is likely to come back
- Is permanent
- Needs rehabilitation or special training for a member to cope with it
- Needs long-term monitoring, including consultations, checkups, examinations and tests

Claims procedures – the document that explains how to make a claim under a plan.

Close family member – a son, daughter, stepson, stepdaughter, legally adopted son, legally adopted daughter, spouse, partner, parent, step-parent, legally adoptive parent, parent-in-law, grandparent, grandchild, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law or legal guardian.

Coinsurance – a percentage of costs a member must pay towards a covered claim.

Conflict or civil unrest – any act of terrorism, war, invasion, foreign enemy hostility (whether or not war is declared), mutiny, riot, strike, civil war, rebellion, revolution, insurrection or attempted overthrow of government, usurped power, martial law or state of siege.

Congenital abnormality – any genetic, physical, biochemical or metabolic defect, disease or malformation, which may be hereditary or due to an influence during gestation, and which may or may not be obvious at birth.

Continuous Transfer Terms (CTT) – continuation of the same underwriting terms, including any special exclusions, that applied with a previous insurer. The underwriting terms with us can be CTT previously moratorium. Members will not be subject to any new personal underwriting terms. Cover will still be governed by the benefits, terms and conditions of the plan with us. See the "Transfers" or "Group member transfers" section and the CTT previously moratorium definitions for more information.

Country of nationality – any country for which a member holds a valid passport.

Country of residence – the country a member lives in for most of the time, usually for a period of at least six months during a plan year.

Critical – a medical condition that, in our reasonable opinion, is unstable and serious, where the outcome cannot be medically predicted, the prognosis is uncertain and the person may die.

CTT previously moratorium – continuation of a member's moratorium start date if they had moratorium underwriting terms with a previous insurer. They will not be subject to any new personal underwriting terms. Cover will still be governed by the benefits, terms and conditions of the plan with us, including exclusion E1.

Date of joining – the date when a member first enrolled or re-enrolled if there is a break in their cover.

Daycare – where treatment is received at a hospital or daycare unit, medical supervision is needed for four or more hours for recovery and the member does not stay overnight.

Deductible – any coinsurance, excess or reasonable and customary deduction that applies to a plan.

Dental – that which affects the teeth and gums.

Dependant – a main member's spouse or partner:

- Unmarried child, stepchild or legally adopted child under the age of 18.

Diagnostic tests and procedures – any medically necessary test or examination to investigate the cause of a member's signs or symptoms.

Direct billing – where we settle costs of outpatient treatment or services directly with a provider in the network.

Eligible – the costs for treatment or services that qualify under the plan, as described in the plan documentation.

Emergency – a sudden, unexpected acute medical condition or an unexpected acute episode of a chronic medical condition that, in our reasonable opinion and based on advice if available, presents a clear and significant risk of death or imminent serious damage to bodily function.

End date – the last day a member has cover under a plan.

Excess – an amount a member must pay towards the cost of part, or all, of a covered claim or claims.

Foreseeable – a medical condition that, in our reasonable opinion, could be reasonably anticipated.

General advice – any medical opinion or medical recommendation from a relevant professional body in relation to a medical condition or treatment, which confirms, in our reasonable opinion, established medical practice or opinion.

Group formation application – the document entitled "Summit Group plan application" which must be completed and signed by the plan sponsor to agree to the terms of the plan plus any supporting information given in connection with it.

Group member application – the document entitled "Summit Group member application" which must be completed and signed by the member to agree to the terms of the plan plus any supporting information given in connection with it.

Home country – the country a member is from as given to us on their application.

Hospital – an establishment that is licensed to provide inpatient, daycare and outpatient medical and surgical treatment in accordance with the laws of the country in which it is situated.

Ineligible – the costs for treatment or services that do not qualify under the plan, as described in the plan documentation.

In-house doctor – a doctor who is employed by the hospital, is considered a permanent member of staff and charges in line with hospital tariffs.

Inpatient – where treatment is received at a hospital and, based on advice, the member needs to stay in a bed for one or more nights.

Intrinsic value – the actual cash value of an item at the time of loss or damage, including appropriate deductions for wear and tear.

Lifetime limit – the total amount that will be paid for any eligible claim for costs incurred during any time a member is covered on any one or more plans with the same or equivalent benefit, even if there is a break in their cover. See plan term P9 for more information.

Material fact – information which you have given us which, in our reasonable opinion, is likely to influence us in our assessment, acceptance or renewal of your membership of the plan, or in making any changes to the plan. This includes, but is not limited to your responses to our questions about yourself, your lifestyle, your health or your medical conditions.

Medical condition – any signs or symptoms, injury, illness or disease.

Medical History Disregarded (MHD) – we will cover a member's pre-existing medical conditions, subject to the benefits, terms and conditions of the plan. Exclusion E1 will not apply.

Medical necessity, medically necessary – treatment that is prescribed by a member's medical practitioner or attending specialist, is in line with general advice, and in our reasonable opinion, is appropriate for their medical condition.

Medical practitioner – a person who:

- has attained primary degrees in medicine or surgery by attending a medical school recognised by the World Health Organisation, and
- is licensed by the relevant authority to practice medicine in the country where the treatment is given.

Medical professional – any medical practitioner, specialist, nurse, therapist, psychiatrist, or qualified and registered psychotherapist or psychoanalyst.

Member – a person we have agreed to cover under a plan as named on the Certificate of insurance.

Medical ID Card – a card we issue for each member, which provides basic plan details and contact information.

Member/Insured Person/You/Your – A person who is an APC member or is a dependant of an APC member.

Moratorium – a waiting period of 12 months from a member's date of joining, or the date shown in the special terms on their Certificate of insurance, that must have passed before claims for pre-existing medical conditions or related medical conditions may become eligible. See exclusion E1 for more information.

Natural teeth – any teeth that are original, not artificial implants or replacements.

Network – all of the providers with whom there are healthcare arrangements for our members.

Nurse – a person who is qualified in nursing, currently practising and on the professional register of nursing in the country where the treatment is given.

Orthodontic – that which affects the structure, function, development or appearance of the teeth, upper or lower jaw or the oral cavity.

Outpatient – where treatment is received at a medical facility that is recognised by the relevant authority in the country where the treatment is given, and the member is not admitted for inpatient or daycare treatment.

Palliative treatment – any medical or surgical services aimed to relieve the symptoms rather than to cure, stop, reverse, or delay the progression of the medical condition causing them.

Partner – a person who is in an established personal relationship with the main member, but is not married to the main member.

Personal effects – personal belongings, including clothing worn and baggage owned by a member, that they take with them on their trip.

Plan – our contract of insurance (made up of all of the documents which form the plan documentation) with the plan sponsor, which takes effect on the plan start date.

Plan administrator – the person who acts as the plan coordinator on behalf of the plan sponsor, as chosen by the plan sponsor.

Plan documentation – Group formation application(s), Certificates of insurance, Plan sponsor guide(s), Handbook(s), Benefits schedule(s), final membership census, Group member applications (if these apply), Group member declarations (if these apply) and Claims procedures.

Plan renewal date – the date when a new plan year is due to begin, as shown on a Certificate of insurance.

Plan sponsor – the entity that purchases a plan for eligible main members, and their eligible dependants where agreed.

Plan start date – the first day of each plan year, as shown on a Certificate of insurance.

Plan year – the period of cover from the plan start date to the day before the plan renewal date, as shown on a Certificate of insurance. This is usually a period of 12 months.

Preauthorisation – our assessment of treatment, services or costs before they are received or incurred.

Preauthorised – any treatment, services or costs that we approve as a result of preauthorisation.

Pre-existing – any medical condition or related medical condition that, in our reasonable opinion, has any one or more of the following characteristics:

- Was foreseeable
- Clearly showed itself
- A member had signs or symptoms of
- A member asked for advice about
- A member received treatment for
- To the best of a member's knowledge, they were aware they had

Preventative services – medical services received when no signs or symptoms are present, and they are not received in relation to a diagnosed medical condition.

Public transport – any paid and licensed type of transport.

Related medical condition – any injury, illness or disease that, based on advice or general advice, we determine is the result of any one or more other medical conditions.

Routine health check – diagnostic tests or procedures where no signs or symptoms are present, and they are not received in relation to a diagnosed medical condition. This includes any cancer screening a member receives after they have been in remission for more than five years.

Specialist – a medical practitioner who, in the country where the treatment is given:

- has a recognised certificate of higher specialist training in the relevant field of medicine, and
- has a consultant appointment or equivalent.

Start date – the first day a member has cover under a plan during a plan year, as shown on their Certificate of insurance.

Terminal – the end stages of a medical condition where life expectancy is considered to be days or weeks and only palliative treatment and care is given.

Therapist – a physiotherapist, podiatrist, osteopath, chiropractor, Chinese herbalist, ayurvedic practitioner, acupuncturist or homeopath, who is qualified and licensed in the country where the treatment is given.

Treatment – any medical or surgical service, including diagnostic tests and procedures, needed to diagnose, relieve or cure a medical condition.

Visiting doctor – a medical practitioner or specialist who is not employed by the hospital, but has a contract to use the hospital facilities and may have different charges to the hospital tariffs.

We/our/us – Al Ain Ahlia Insurance Company Limited (PSC).

You/your/yourself – you as a member.

9 Your guide to making a claim

In order to ensure that members receive the best possible claims service, the procedures noted below should be followed in the event of treatment being required.

Please ensure your claim form is completed in full and returned within 180 days of the treatment date.

For all medical related claims, please send an email to your broker, AES International, at **apc@aesinternational.com**.

Local Plan Benefits

The policy provides cover for treatment as a secondary cover to your employer's plan/local plan. All claims must be supported by documentation from your employer/local plan provider evidencing that either your diagnosis is not covered or that your plan benefit limits have been exceeded. You must claim from your employer's scheme before making a claim with us.

Pre-existing conditions have a one-year waiting period applied for all new entrants to the medical scheme. If they are existing APC members or added dependents if the main member has been on the policy for more than a month, the waiting period will apply. This is to protect the insured population from members joining only when they develop major medical conditions. This is based on the main members joining date.

This plan is not DHA compliant and will only serve as a top-up to an employer's DHA-compliant cover whilst you are a Dubai resident. If you do not have a primary DHA plan in place in Dubai then this cover will not be applicable.

Claim Submission

We reserve the right to deny any claim that is not submitted within 180 days of the treatment date. Claims may only be made for treatment given during a period of cover.

The benefit will only be payable for expenditure incurred prior to expiry or termination.

All required supporting claims documents and materials (including, but not limited to, original accounts, certificates and x-rays) shall be provided without expense to us. This includes medical reports from **your medical practitioner** or **specialist** and details of **your** medical history, if requested by us.

Charges from an attending **medical practitioner** or **specialist** for completing claim forms are not **eligible** for reimbursement under the terms and conditions of this **plan**. **Members** will be responsible for these costs.

We will require a medical practitioner's or **specialist**'s referral to be included whenever filing a claim for the following **treatment**s:

i) Chiropractic **treatment**

ii) Acupuncture **treatment**

iii) Osteopathic **treatment**

iv) Homeopathic **treatment**

v) Podiatric **treatment**

vi) Physiotherapy (additional referral by a **specialist** required after 10 sessions)

We accept soft copies of original receipts to start the claim process and to facilitate the assessment of **your** claim (i.e., if you submit claims via fax or e-mail); however, you should keep **your** original receipts on file in case they are needed for verification purposes.

The International Bank Account Number (IBAN) will be mandatory for all bank transfer transactions in the UAE. Please ensure this information is provided on **your** claim form to enable claim settlements.

Claim Notification

The policyholder, or the insured person, shall inform us promptly upon becoming aware of the insured incident. When the policyholder, or the insured person intentionally or due to material default fail to inform us in a timely way and this causes difficulty in identification of the nature, cause, degree of loss, etc., then we shall not be liable for payment of insurance compensation for the portion that cannot be identified, with the exception that we ought to have known such incidents through other channels.

Pre-Authorisation

We require **members** to obtain prior approval (pre-authorisation) from us before commencing the following **treatment**s:

i) **Plan**ned **inpatient** or day patient **treatment** (hospitalisation)

ii) Any pregnancy or childbirth **treatment** (as specified under section 22 of the benefit schedule)

iii) **Plan**ned surgery

iv) Home nursing charges

v) **Plan**ned MRI, PET and CT scans

We also require pre-authorisation when seeking emergency evacuation. Failure to obtain pre-authorisation from us when commencing any of the above **treatment**s may result in **your** claim being declined by us.

Emergency/Evacuation

In the event of a true medical emergency or evacuation, **members** may contact us at the appropriate number found on **your** Aetna International membership **ID card**.

Inpatient and Day Patient Treatment

Our prior approval (pre-authorisation) must be obtained for all **plan**ned day patient and **inpatient treatment**.

Inpatient and Day Patient Treatment outside the U.S.

When we have been notified of an **eligible** day patient/ **inpatient** stay, we will attempt to arrange direct settlement with the **hospital** and the **medical practitioner**s or **specialists** concerned. We will send the **hospital** a guarantee of payment for the estimated cost of the **treatment**, as indicated by the relevant facility/provider, which will confirm to them that the **treatment** is covered under **your plan**.

- *Release of Medical Information Form*
  You will be required to complete a release of medical information form, which you should forward to us as soon as possible. Delays in completing this may result in delays in receiving **treatment**.
- *Pre-certification Medical Form*
  The **hospital** is required to complete a pre-certification medical form outlining details of the medical **treatment** to be undertaken. We cannot place a guarantee of payment without these two documents, so please ensure that the **hospital** confirms with you that this has been sent to us. We will verbally confirm that **your treatment** is covered under the terms of the group **plan**. However, completion of pre-authorisation is conditional on the submission of **our** guarantee of payment. We will notify you as soon as possible if the condition or **treatment** required is not covered.

It is important to contact us as soon as possible prior to **treatment** to ensure we are able to place a guarantee of payment in time. We recommend that you do not delay **treatment** if a guarantee is not in place at the time **treatment** is due.

Day Patient and Inpatient Treatment in the U.S.

For those **members** who benefit from U.S. elective **treatment** or those **eligible** to claim **accident** and emergency **treatment** outside the **area of cover** as a direct result of **treatment** being undertaken in the **accident** and emergency ward of a **hospital** whilst temporarily travelling in the U.S. and where the medical condition did not exist prior to travel.

Please check **your Certificate of insurance** to ensure that you have the appropriate cover before travelling to or undertaking any **treatment** in the U.S.

For emergency admissions, the member, the **hospital** or a family member should contact us to obtain authorisation prior to **your** leaving the **hospital**. Failure to notify us of **inpatient** or day patient **treatment** will mean that you may

only be **eligible** for reimbursement of a proportion of the costs incurred.

- Inpatient or *Day Patient* Treatment in the U.S. *Provider Network*
  We have made arrangements with many provider networks in the U.S., which mean that costs for treatment at these facilities can be settled directly by us.

Treatment received within the provider network will be billed to us directly. We will send you and the provider copies of the explanation of benefits (EOB) detailing how the bill was settled and what amount you are responsible for.

We will notify you as soon as possible if the medical condition or treatment required is not covered by your plan.

- Inpatient or *Day Patient* Treatment in the U.S. received outside the *Direct Settlement Network*
  Treatment received outside the U.S. provider network is subject to limitation and a 50% coinsurance.

Outpatient Treatment outside the Direct Settlement Network (outside the U.S.)

After paying for treatment, you must submit a claim form to us for reimbursement.

If we require medical information when considering a particular claim, but it is not made available to us, it is your responsibility to obtain this information from your current or previous medical practitioner or specialist, as appropriate.

It may not always be possible to have your claim form completed by your medical practitioner, specialist or dental practitioner.In such circumstances, we will settle the claim, provided that the submitted invoice(s)/receipt(s) for treatment are included and contain all of the following:

- The date of service
- The diagnosis or medical condition being treated
- The treatment provided during the visit
- The charged amount
- The stamp of the facility/provider concerned

If physiotherapy, acupuncture, chiropractic, osteopathic, podiatric or homeopathic treatment is required, please ensure that you include a referral letter from your medical practitioner or specialist with your claim.

Settlement of claims may be delayed if you fail to complete your claim form(s) properly. To ensure prompt settlement of any eligible claims, please ensure that you submit all necessary documents at the time of the claim.

Outpatient Treatment in the U.S.

For those who have purchased the U.S. elective treatment benefit or those temporarily travelling in the U.S. and claiming accident and emergency treatment outside the area of cover benefits for outpatient treatment connected with treatment received in the accident and emergency ward of a hospital for a medical condition that did not exist prior to travel.

Please check your Certificate of insurance to ensure that you have the appropriate cover before undertaking any treatment in the U.S.

The terms of the main member's plan will apply to the added dependant. Once we've accepted a proposed dependant, we'll send the main member the new Medical ID card and an updated Certificate of Insurance.

10 How to use your medical insurance

The policy provides cover for **treatment** as a secondary cover to **your** employer's **plan**/local **plan**. All claims must be supported by documentation from **your** employer/ local-**plan** provider evidencing that either **your** diagnosis is not covered or that **your plan** benefit limits have been exceeded. You must claim from **your** employers scheme before making a claim with us.

Important Contact Details

Aetna International
P.O. Box 6380
Dubai, UAE

Tel: +971 4 4387600

For any escalation
Tel: +971 56 525 9263

E-mail: **apc@aesinternational.com**

Gather your documents

Obtain a letter from your employer/primary cover showing why the claim was not covered. This should include diagnosis and reasons for non-cover. It should also mention the amount not covered.

Send them to us

Scan all claim documents and submit the claim directly to our broker AES International at **apc@aesinternational.com** for processing.

Clearly mention "Aviation Professionals Club Claim" as your subject.

Wait for a confirmation e-mail

AES will review the documents and let you know of any additional requirements before submitting it to Aetna.

Documents may include:

- Filled-in Aetna claim form signed by the treating doctor;
- Discharge summary – Inpatient treatment;
- Full breakdown of all charges;
- Prescription for any medication;
- Invoices and receipts as proof of payment, stamped by the medical provider.

Incomplete claims will be on hold until required information or documents are provided.

Aetna will settle your claim using the payment option you've selected on your claim form.

Bank Transfer

Claims settled via bank transfer will be finalized within 10 – 15 working days. Bank transfer is the preferable option as it's faster and all costs are borne by the insurer.

Cheque Payment

Claims settled by cheque may take more than 15 working days from the day of acknowledgment due to processing and delivery times. Cheques will be delivered to the address mentioned on the claim form.

11 Questions and answers

1. When can I join the APC scheme?

You can join the plan at any time. Please note if you join the scheme and then opt out you may not rejoin the health plan, this is applicable to both main members and their dependents. New members to APC will be allowed 30 days from joining to subscribe to the plan during the policy year and will not be subject to the one-year waiting period on pre-existing conditions. The waiting period is only applicable for existing APC members that did not join the scheme earlier, this is applicable to both main members and their dependents.

2. Can a dependant child studying abroad be covered under this plan?

Any child can be added to the policy as long as the parent is a main member and remains a member of both APC and Aetna.

Dependants studying in the U.S. will not be covered, due to non-compliance to the U.S. healthcare requirements. Other countries may have legal requirements to have a locally admitted plan purchased, if you move to one of these countries then this plan cannot be regarded as your primary plan. If you have a dependant child studying abroad but still on a UAE visa then please speak to us to understand the legalities in using your supplemental plan in the UAE.

3. Can I get this policy just for my partner and child (excluding myself)?

The primary APC member must be enrolled in the Summit Plan. Dependants can be added.

4. Can members upgrade their area of cover?

Members need to choose their geographical cover at the time of joining. All family members must be covered under the same geographical cover at the time of joining. Changes in area of cover can be considered at policy renewal but must be referred to our underwriters for approval and may be subject to waiting periods.

5. What happens when someone retires or leaves the UAE?

A member can continue with the plan as long as they remain a member of APC after they retire or leave the UAE. You must also have been a member of the scheme for at least two years and have joined before the age of 58 to be eligible to maintain the policy in retirement or on leaving the UAE. If you do not meet the minimum requirements when leaving or retiring, APC reserves the right to cancel your policy mid-term. Members who qualify will have their APC membership converted to that of an Insurance Associate so they can remain eligible for cover.

6. What happens if a member relocates to the U.S.?

This policy is not available for U.S. residents. Partners and children in the U.S. cannot apply for cover. If you purchase the policy whilst resident in the UAE and move back to the U.S. permanently we will have to cancel the policy as it does not comply with U.S. Healthcare Reforms.

7. What happens if the primary member of APC dies?

As long as the surviving partner remains a member of APC, they are entitled to remain within the APC Summit Plan (subject to certain geographical limitations).

8. What happens when a member leaves APC?

Membership of this scheme is restricted to members of APC. Should a member leave APC, we will consider a transfer to an Individual policy which may be subject to individual underwriting and terms that prevail at that time. This is an annual policy, so members are liable to pay the remaining premium for the entire year even if they leave APC.

9. What are the differences for members in using their employer's plan and the APC plan?

The APC plan is specifically designed as a supplementary insurance scheme. Where the local cover or benefits are either exceeded, or services are not covered, then the APC plan will consider payment under the schedule of benefits. The APC plan has been structured to address the shortfalls, such as low annual limits for children, waiting periods, and other restrictions. Members must use their employer sponsored benefits first, reverting to the APC plan where needed.

All claims must be supported by documentation from your local provider evidencing that either your diagnosis is not covered under your local plan or that your local-plan benefit limits have been exceeded. All claims will only be considered for assessment once your local-plan benefits have been exhausted.

10. What out-of-pocket expense may I have?

You will only have out-of-pocket expenses if you need to take Accident and Emergency Outpatient treatment outside your area of cover. In this case, an excess of $80 per condition applies. The supplementary plan is not designed to cover all excluded or exhausted benefits on your primary plan. You must refer to the table of benefits to see what we will cover.

11. How do I pay for my premiums?

Premiums will be paid to APC, using one of the following methods:

- Up front for the 12 months by cash, debit card or bank transfer
- Monthly Direct Debit

12. Will the plan cover any illnesses or injuries that members have prior to enrolling in the plan?

New APC members can get pre-existing cover from day 1, if enrolled within 30 days of joining the club. For new members enrolling after 30 days on an APC membership, costs will be covered after the initial one year waiting period for pre-existing conditions. Members with new conditions after joining the scheme that need treatment will be eligible to have claims paid.

13. Does the APC plan cover the deductible/excess amount I have to pay for my employers cover?

No, we will not cover this excess/deductible charged by your employer. This is not a covered item as per your table of benefits. This will not be applicable for for Inpatient copayment Plan.

14. Can I cancel the policy midterm?

If you are a resident of the UAE you can cancel the policy mid-term on producing a copy of cancelled resident visa. This applies to Members, Partners and dependents. Mid -term cancellations are not available to Insurance Associates & their Dependents. An admin fee of 1 month premium will be applied – and refund will be permitted up to two months prior to renewal date in line with APC membership cancellation policy.

15. What happens if I leave my employer but remain in the UAE?

This plan is not compliant with DHA or DOH regulations as a primary insurance plan. Coverage will cease if you lose your primary insurance coverage for any reason and decide to stay in the UAE. You must either convert this plan to a fully insured plan with Aetna or purchase a basic DHA/DOH plan to stay a member.

A change in your employer will also have an effect on your APC membership. You will have to remain a full member with APC if you are in the UAE and wish to continue on the medical plan.

16. What happens when I return to my home country and wish to avail of treatment through the government hospitals?

As a member of the Aetna plan, members may use the plan as their primary insurance provided that there is no mandatory insurance plan required in that country of residence. In cases where there is mandatory insurance required, the Aetna plan will be used as the secondary plan.

As an Aetna member you may use the Aetna insurance policy as your primary insurance plan.

17. Can I cancel the policy mid term?

If you are a resident of the UAE you can cancel the policy mid-term on producing a copy of a cancelled resident visa. This applies to Members, Partners and dependents. Mid-term cancellations are not available to Insurance Associates and their Dependents. An admin fee of 1 month premium will be applied – and a refund will be permitted up to two months prior to renewal date in line with APC membership cancellation policy. A refund will only be applied if the member has utilized 40% or less of their total earned premium paid excluding VAT towards claims (paid claims). Members who have utilized more than 40% of their total premium will not be eligible for a refund..

18. Not happy with the outcome of your claim?

If you are not happy with any part of your claim experience please contact the APC insurance desk or our broker AES international at **apc@aesinternational.com**.

19. Is the plan eligible for Abu Dhabi visa holders?

No, this is a top up plan which is not compliant as per the Department of Health - Abu Dhabi regulations. Coverage under this plan is only available to non-Abu Dhabi residents.

20. If I cancel the policy, can I rejoin?

It is not possible to rejoin the policy after cancellation.

The extra bits

12 Employee (Member) Assistance Programme

Staying on top of the demands of work, family and finances can be challenging. Our Employee (Member) Assistance Programme (EAP) helps employees stay productive in the workplace while taking care of personal issues.

This programme gives your employees access to confidential counselling from behavioural health experts in 180 countries around the world. It is made possible through collaboration between our in-house experts, based in the United States, and our global partner, WorkPlace Options.

Online self-help programmes, telephone and in-person counselling

Help for everyday living

- Improving family communication
- Achieving work-life balance
- Coping with life changes
- Managing stress
- Surviving the loss of a loved one
- Living with anxiety or depression
- Addressing substance use
- Handling bullying and harassment
- Managing workplace pressures
- Navigating couples challenges
- Tackling parenting concerns
- Caring for an older person

Free, confidential support

- Up to five free counselling sessions per concern, per year
- Multilingual, worldwide support around the clock
- Telephone support from behavioural health experts
- In-person sessions for members on select plans
- Referral to legal and financial resources
- Easy access through Member Services.

13 Aetna Security Assistance

Far away from home should never mean far away from support.

As an Aetna International member, you have access to the security advice and assistance you need to keep you safe.

Aetna Security Assistance powered by Crisis24 gives you:

- **24/7 access** to personalised advice from a team of multilingual crisis support specialists and political risk analysts
- **Intelligence and security advice** on over 220 countries and territories and over 500 cities worldwide
- **Personalised travel reports and safety briefings** when you submit a request for bespoke location-based analysis and information in relation to a developing or existing situation
- **Email and text alerts** providing up-to-the minute information on civil unrest, natural hazards and travel disruptions
- **Worldwide security news** through daily summaries that provide information on global noteworthy, risk-related events and developments

Register now

1. Go to **my.worldaware.com/aetna**
2. Register using the plan number: AETNA2021
3. Create your log-in user name and password
4. Once activated you'll be taken to your Crisis24 homepage to learn about the services available to you.

Phone

For 24/7 security assistance or help logging in, call:
+44 (0)207 741 2175 or +1 646 513 4232

Aetna Security Assistance
Powered by

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

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Al Ain Ahlia and Aetna do not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to **www.aetnainternational.com**.

If coverage provided by this policy violates or will violate any United States (U.S.), United Kingdom (UK), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Al Ain Ahlia 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 U.S., unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit **www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Policies are underwritten by Al Ain Ahlia Insurance Co. (PSC), incorporated under the Abu Dhabi by Act 18 of 1975, Insurance Registration No. 3 of Law No. 6 of 2007 concerning the establishment of UAE Insurance authority and its regulations, and administered by Aetna Global Benefits (Middle East) LLC (Registration No. 5). Registered address: 28th Floor, Media One Tower Building, Dubai Media City, TECOM, PO Box 6380, Dubai, UAE.

Important: This is a non-U.S. insurance product that does not comply with the U.S. 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 U.S. 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 U.S. taxpayers.

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