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Benefits for healthy beginnings
Aetna Maternity 75 & 150 Benefits schedule

USD

For plans with a start date on or after 1 January 2016

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M069-89E-010116

Whether you're choosing a plan or choosing how to use it, **this Benefits schedule will provide the details you need**.

Aetna Maternity 75 & 150
Benefits schedule 2016

You or **your** personal representative must request **preauthorisation** for any:

- Medical evacuation
- **Inpatient** or **daycare treatment** admission
- Single **treatment** or service that costs more than USD 500 or equivalent

All **preauthorisation** must be requested before **treatment** or services are received or costs are incurred. If it is not possible to request **preauthorisation** for an **emergency we** expect to be notified of the event within 24 hours. See **your Claims procedures** for full details. Please also see condition C3 in **your** Handbook.

		Aetna Maternity 75	Aetna Maternity 150
1	**OVERALL PLAN LIMIT**		
1.1	Reasonable costs will be paid for **you** up to the overall **plan** limit in the **plan year**. **We** will not pay any more than the overall **plan** limit for any one or more claims on any one or more of the **benefits** below. Where a **benefit** limit is shown as 'Paid in full', this is still subject to the overall **plan** limit. All **benefit** limits shown below apply to each pregnancy. Where a pregnancy spans more than one **plan year**, any **benefit** paid for **treatment** or services received in the **plan year** when the pregnancy began will be deducted from the **benefit** limit shown in the following **plan year**.	USD 1,700,000	USD 1,700,000
2	**PREGNANCY AND CHILDBIRTH (SEE SECTION 6 FOR DEDUCTIBLES)**		
2.1	Costs for: • Antenatal checkups for an uncomplicated pregnancy • Antenatal vitamins • Delivery costs, nursing fees and **hospital** accommodation costs for uncomplicated childbirth • Postnatal checkups This **benefit** includes cover for pregnancies resulting from natural or assisted conception. Cover for antenatal checkups includes no more than 12 routine antenatal visits during each pregnancy and one routine 2D ultrasound scan in each trimester. If any additional antenatal visits or ultrasound scans are **medically necessary**, **we** will ask for further medical information so **we** can consider cover under section 2.2 or 2.3. **We** will pay reasonable **hospital** accommodation costs for the newborn to stay with **you** for no more than four nights immediately after childbirth. **We** will also pay the following routine costs for the newborn: • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination This **benefit** is only available after **you** have had 12 months' continuous cover from **your date of joining** this **plan**.	Paid up to USD 7,500	Paid up to USD 15,000

		Aetna Maternity 75	Aetna Maternity 150
2.2	**Treatment** for medical complications of maternity that happen due to a **medical condition** during pregnancy or childbirth, if the pregnancy is the result of assisted conception. This includes the costs of durable medical equipment. **We** will pay reasonable accommodation costs for the newborn to stay with **you** immediately after a complicated childbirth. **We** will also pay the following routine costs for the newborn: • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination This **benefit** is only available after **you** have had 12 months' continuous cover from **your date of joining** this **plan**.	Paid up to the limit shown in Section 2.1	Paid up to the limit shown in Section 2.1
2.3	**Treatment** for medical complications of maternity that happen due to a **medical condition** during pregnancy or childbirth, if the pregnancy is the result of natural conception. This includes the costs of durable medical equipment. **We** will pay reasonable accommodation costs for the newborn to stay with **you** immediately after a complicated childbirth. **We** will also pay the following routine costs for the newborn: • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination	Paid up to USD 15,000	Paid up to USD 50,000
2.4	This **benefit** does not extend to 3D or 4D ultrasound scans. Routine costs for newborns, as shown in section 2, are only covered for the first 30 days from birth. Where the newborn is an insured **member** on an Aetna Pioneer **plan**, cover for routine costs within the first 30 days will still be provided under section 2 of the insured mother's Aetna Maternity **plan**. Durable medical equipment does not extend to the supply, modification or fitting of furniture, or any modifications to **your** personal or work environment.		

3	MEDICAL EVACUATION		
3.1	The costs to transport **you** to the nearest location where appropriate medical facilities are available, as agreed by **us** and by **your** attending **medical practitioner**. This **benefit** will only be paid: • for medical complications of maternity that happen due to a **medical condition** during pregnancy or childbirth, • if the **medical condition** is an **emergency**, and • if **we** agree appropriate **treatment** is not available locally. This **benefit** extends to the costs for emergency **treatment you** receive during the journey. Where it is necessary to transport **you** outside **your area of cover**, any related costs that are incurred in the country **you** are evacuated to will be payable under the sections of **your Benefits schedule** that would normally apply when **you** are within **your area of cover**. Cover is only available under this **benefit** if the **treatment** is covered under section 2 and **you** have completed any waiting periods shown in section 2.	Paid in full	Paid in full
3.2	Economy class travel costs for **you** to go back to **your country of residence**, or **your home country**, after **your** emergency medical evacuation under section 3.1.		

		Aetna Maternity 75	Aetna Maternity 150
3.3	Costs of one **dependant** or companion having to accompany **you** for an emergency medical evacuation under section 3.1. This **benefit** will only become available if **your medical condition** is **critical** or **you** are expected to stay in **hospital** for seven or more nights. **We** will cover: • Costs for return economy class travel, including taxi transfers to and from the hotel on arrival and departure • A taxi from the hotel to the **hospital**, and back, once a day • Reasonable overnight accommodation costs, to include breakfast	Paid in full	Paid in full
3.4	The costs to transport **you** to appropriate medical facilities for **treatment** related to **your** pregnancy if the **medical condition** is not an **emergency**. **We** will cover costs for return economy class travel to a location of **your** choice within **your area of cover** if: • **we** agree appropriate **treatment** is not available locally, and • **we** agree appropriate **treatment** is available in **your** chosen location. **We** will also pay for airport taxi transfers. **You** are limited to three return journeys for each pregnancy. Cover is only available under this **benefit** if the **treatment** is covered under section 2 and **you** have completed any waiting periods shown in section 2.	Not covered	Paid in full
3.5	Costs for medical evacuations do not extend to air-sea rescue, or any mountain rescue unless related to a **medical condition you** suffer at a recognised ski resort or similar winter sports resort.		

4	LOCAL AMBULANCE		
4.1	Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local **hospital** because of an **emergency** or due to **medical necessity**, when related to **your** pregnancy or childbirth. Cover is only available under this **benefit** if **treatment** is covered under section 2 and **you** have completed any waiting periods shown in section 2.	Paid in full	Paid in full
4.2	Costs for local ambulances do not extend to air-sea rescue, or any mountain rescue unless related to a **medical condition you** suffer at a recognised ski resort or similar winter sports resort.		

5	EMERGENCY TREATMENT OUTSIDE AREA OF COVER		
5.1	**Inpatient** and **daycare treatment** for medical complications of maternity that happen due to a **medical condition** during pregnancy or childbirth, if the medical complication is an **emergency** and **you** are outside **your area of cover**.	Paid up to USD 7,500	Paid up to USD 15,000
5.2	**Outpatient treatment** for medical complications of pregnancy that happen due to a **medical condition** during pregnancy, if the medical complication is an **emergency** and **you** are outside **your area of cover**.	Paid up to USD 250	Paid up to USD 500
5.3	Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local **hospital**. This **benefit** will only be paid for medical complications of maternity that happen due to a **medical condition** that is an **emergency** during pregnancy or childbirth when **you** are outside **your area of cover**.	Paid up to USD 500	Paid up to USD 500
5.4	Cover is only available under this **benefit** if the **emergency** would normally be covered under section 2 when **you** are within **your area of cover** and **you** have completed any waiting periods shown in section 2. If **you** are 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.		

		Aetna Maternity 75	Aetna Maternity 150
6	**DEDUCTIBLES**		
6.1	**Coinsurance** on sections 2.1 and 2.2. This **coinsurance** is applied to each claim. An additional **deductible** may apply for **treatment** or services received outside of the **network**, see section 6.2.	10% If a voluntary **coinsurance** of 0%, 20% or 30% has been chosen, this will apply instead.	10% If a voluntary **coinsurance** of 0%, 20% or 30% has been chosen, this will apply instead.
6.2	Out-of-**network deductible** on section 2 if: • an appropriate provider within the **network** is available in the location where **you** receive **treatment** or services, but **you** receive **treatment** or services at a provider outside of the **network**, and • the cost of **treatment** or services is greater than the cost that would have been incurred if the **treatment** or services were received within the **network** in the same location. The value of the **deductible** will be the difference between the cost of the **treatment** or services received and the cost that would have been incurred if the **treatment** or services were received within the **network** in the same location. This **deductible** is applied to each claim before the deduction of any other applicable **deductible** shown in section 6.1. This **deductible** does not apply if the **treatment** or services received are needed due to an **emergency**.	Deduction for reasonable and customary costs	Deduction for reasonable and customary costs
6.3	After any applicable **deductibles**, the maximum amount **we** will pay for any one or more claims will be the amount shown in the relevant section above.		

All cover provided under this **Benefits schedule** is subject to the terms and conditions of **your plan**.

Some words and phrases used in this **Benefits schedule** have specific meanings that are relevant to **your plan**. **We** have highlighted them in bold print and defined them in the 'Definitions' section of **your** Handbook.

Areas of cover, eligibility and coinsurance

Aetna Maternity **plans** are only available with the same **area of cover** as **your** Aetna Pioneer **plan**. Aetna Maternity 75 and 150 are only available with Areas 2 to 7. If Area 1 is **your area of cover** on **your** Aetna Pioneer 5000 or 5000+ **plan**, please see the Aetna Maternity 200 **Benefits schedule**.

Cover under this **plan** is only available if **you** are a female **member** and **your** Aetna Pioneer **plan** is in force. The Aetna Maternity **plan** levels shown above are available as follows:

- Aetna Maternity 75 is only available with Aetna Pioneer 2500, 4000 and 5000
- Aetna Maternity 150 is only available with Aetna Pioneer 4000 and 5000

Aetna Maternity **plans** are not available with Aetna Pioneer 1750.

The minimum age at entry for this **plan** is 18. The maximum age at entry is 44. Once **you** have reached the age of 46 during **your plan year**, **your** Aetna Maternity **plan** will not be renewed. For full eligibility details, see **your** Handbook.

The maternity **coinsurance** chosen will apply for the first 24 months' continuous cover under the **plan**.

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

Notice to United Kingdom residents: In the UK, Aetna Insurance Company Limited (FRN 458505) has issued and approved this communication.

Notice to all: Please visit **www.aetnainternational.com/ai/en/about-us/legal/regional-entities** for more information, including a list of relevant entities permitted to carry on or administer insurance business in their respective jurisdictions.

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

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