Introducing Summit

We understand that moving from one health policy to another must be a straightforward and clear move, for the convenience of members, clients and business partners. To help you understand your new policy with us, in this document we highlight the key differences compared to your current policy.

You will find the complete overview of your new Summit plan cover in your Table of Benefits. All the applicable terms and conditions are detailed in the Employee Benefit Guide, available to download from https://www.allianzcare.com/summit.

If you have any queries regarding your new cover or the key changes outlined in this document, please do not hesitate to contact us.

Cover structure

Your company was insured under an Healthy Aessentials Plan (AHA) and will be transferring to a Summit plan.

The AHA benefit selections previously made by your company will be mapped to the closest available Summit plan.

Improvements in the move to Summit

- If your **area of cover** on your AHA plan was 'Asia and Pacific Rim' or 'Asia, Pacific Rim and Singapore', you will be upgraded to 'Worldwide excluding US' cover on your Summit plan.
- Costs for the treatment of **chronic conditions** are now covered under the various benefits listed in your Summit plan, unless excluded as part of a full medical underwriting or moratorium policy. On AHA, these costs may have been limited to a specific monetary amount.
- **Repatriation of mortal remains or burial expenses** is now covered in full regardless of the plan you are on. With the AHA plans, **mortal remains** was an optional benefit.
- **Kidney dialysis** is covered in full on an in-patient, day-case and out-patient basis across all Summit plans. On the AHA plans, kidney dialysis was only covered on an in-patient basis, or immediately prior or following hospitalisation.
- Regarding **newborn care for babies conceived via assisted conception**: For newborns, in-patient treatment for complications arising from assisted conception was excluded on AHA plans. On your Summit plan, you will not find this restriction; however, there will be a limit for in-patient treatment that takes place in the first three months following birth, if the baby is born by surrogacy or is a multiple-birth baby born as a result of medically assisted reproduction. This limit is $40,500 per child* and it applies before any other benefit in your plan. Out-patient treatment is paid under the terms of the Out-patient Plan.

  **Please note that this limit also applies to babies that are adopted or fostered.*
- Regarding **newborn care for babies conceived via natural conception:** Your AHA plan applied a monetary limit as well as a maximum number of days stay in hospital for treatment of acute medical conditions occurring within 30 days from birth. On your new Summit plan, no specific limits apply to newborn care for babies born via natural conception; cover will be provided as part of in-patient, day-care and out-patient benefits.
- **Palliative care** is now covered in full on the Summit 2500, 4000 and 5000 plans. On AHA, palliative care was only covered in relation to Oncology treatment.

- An **in-patient cash benefit** is available at $125 per night across all Summit plans, as standard. On the AHA plans, this was an optional benefit.

New benefits

The Summit plans feature several new benefits. Please refer to your Table of Benefits to find out more about these additions, including applicable benefit limits, co-payment, deductibles or waiting periods.

- **'Emergency out-patient dental treatment'** is available as standard on the Summit 2500, 4000 and 5000 plans. This benefit covers all types of dental emergencies treated within 24 hours of the emergency event (both acute medical conditions as well as accidental damage, including that caused by eating).

  On AHA, cover was available only if an optional Dental benefit was purchased, or partially covered if the optional '**Accidental damage to teeth'** benefit was selected.

- **'Long term care'** is included on all plans:

  Long term care *refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home.*

- **Prescribed hearing aids** are now covered under the new 'Prescribed medical aids' benefit as standard:

  Prescribed medical aids *refers to any device which is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:*

  - *Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.*
  - *Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.*
  - *Hearing and speaking aids such as an electronic larynx.*
  - *Medically graduated compression stockings.*
  - *Long-term wound aids such as dressings and stoma supplies.*

- **Employee Assistance Programme (EAP)** and **Travel Security Services** are included as standard services across all Summit plans – please refer to your Table of Benefits for details

Other changes

- On the AHA plans, several benefit limits were applied on a **'per medical condition'** basis. On Summit, these benefit limits will instead be applied on a 'per Insurance Year', 'per lifetime' or 'per discharge' basis.

- If your AHA plan included an **'out-patient co-pay per visit**', note that in your Summit plan an 'out-patient co-payment %' will apply instead. The 'co-pay per visit' selection made by your company will be mapped to the most appropriate co-payment option in the move to Summit.

- The **'Durable medical equipment'** benefit on the AHA plans will be called 'Prescribed medical aids' on the Summit plans.

- Cover for **emergency treatments received outside your area of cover** has changed in your move from the AHA to Summit plans. You will have one benefit called 'Emergency treatment outside area of cover (for trips of a maximum period of six weeks)' in your Table of Benefits – this covers for up to 42 days of treatment per year, with the following benefit limits:

  - $13,500 on Summit 1750 and Summit 2500
  - Full refund up to max. 42 days) on Summit 4000 and Summit 5000

  Within this benefit, we will not apply further limits for out-patient treatment required for emergencies outside your area of cover (as per your current AHA plan).

  It is also important to note that on the AHA plans, all conditions that existed prior to travel were excluded; whereas on the Summit plans, cover for conditions existing prior to travel may be covered - depending on your underwriting terms.

- If you had the '**Congenital anomalies**' benefit on your AHA plan, this will be called 'Congenital conditions' on the Summit plan. The benefit limit on your Summit plan will only apply to in-patient and day-care treatment and not to out-patient treatment. Out-patient treatment of congenital conditions will be covered under the out-patient benefits in your plan. The benefit limit on Summit is applied on a 'per lifetime' basis, whereas on the AHA plans, the limit was applied 'per medical condition'.

- If you are moving to the Summit 1750 Plan, you will unfortunately no longer have the benefit PET, CT scans and MRI scans on out-patient basis.

- On Summit, there is no requirement to seek pre-approval for most **direct settlement out-patient treatment** over $100. Pre-approval is still required on several high cost or long-term outpatient treatments; please refer to your Table of Benefits for details.

Accessing treatment

The process regarding accessing treatment will be slightly different under your new policy. You will find a complete description in the Benefit Guide – please find below a short summary for your convenience:

1. Some benefits included in your new Summit plan will be indicated in the Table of Benefits as subject to **pre-approval**. These benefits are usually in-patient treatments or high cost treatments. For these benefits, insured members will need to send us a Treatment Guarantee Form in advance: this will help us assess each case, organise everything with the hospital before their arrival and make direct payment of the hospital bill easier, where possible.

   If pre-approval via Treatment Guarantee Form is not obtained, the following will apply:

   - If the treatment received is subsequently proven to be medically unnecessary, we reserve the right to decline the claim.

   - If the treatment is subsequently proven to be medically necessary, we will pay 80% of in-patient benefits and 50% of other benefits.

   In case of **emergency treatments**, the insured member can simply access the treatment they require and inform us within 48 hours of any hospital admission. We can take Treatment Guarantee Form details over the phone at that point.

2. For any other benefit that is not indicated in the Table of Benefits as subject to pre-approval, the insured member can simply pay the medical provider upfront and then claim the eligible costs via our MyHealth digital services (available as portal and mobile app).

3. **Claiming deadline**. Your cover under the Summit plan offers an extended claims submission timeline, where we will accept claims for processing up to six months after the end of the Insurance Year they refer to, as opposed to up to six months after the treatment date as applicable under your AHA plan.

4. **Medical provider network.** The list of medical providers that facilitate out-patient direct settlement on Summit may differ from the list on AHA. We are expanding our provider network as we endeavour to make sure that access to key medical providers is available.