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Healthier living  
Financial well-being  
Intelligent solutions

**aetna**<sup>SM</sup>

# International Healthcare Plan **Member Handbook**

Effective date: Policies issued from 1 April 2012

[www.aetnainternational.com](http://www.aetnainternational.com)



# The Aetna difference

For over 155 years, we have been working to make it easier for our members to access health care. Our first-class service places you at the centre of everything we do — so you can access the care you need, when you need it. This handbook contains helpful details about your **International Healthcare Plan**, including how to file a medical claim, how to contact us and much more.

**It's time for you to experience the Aetna difference.**

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## International Healthcare Plan overview

The International Healthcare Plan is designed with the needs of globally-mobile individuals in mind.

To find out about the key features of the plan, including details on the benefits, please refer to your separate benefits schedule.

You may also contact the International Member Service Centre by dialling the number on your member ID card.

### Value-added wellness programmes

**Aetna Global Health Connections is a suite of complimentary wellness programmes that include:**

- **Wellness Checkpoint®**

Wellness Checkpoint is a culturally diverse, online health survey that provides you with information about your personal health needs and motivates you to make lasting positive changes. The tool can also help you understand possible health risks, and provides an action plan and information that encourages healthy behaviours.

- **Cancer outreach and support**

Members with cancer can get assistance to help them understand their condition and locate helpful resources without a “one size fits all” approach. Instead, each interaction is customised to your unique health situation. You can speak one-on-one with a registered nurse who is committed to helping you manage your disease and reach your best health.

- **Health and wellness education**

Whether you are healthy and looking for additional healthy lifestyle tips — or have a chronic condition and want to learn how to reach your optimal state of health — we offer an array of health and wellness education materials to aid you in your efforts. The Aetna International Wellness Centre provides helpful information, including health topics such as:

- Asthma
- Cancer
- Coronary Artery Disease
- Maternity
- Stress Management

# Our service philosophy

We work daily to connect you to the care you need.

## 24x7 member services

Our multilingual, multicultural member service professionals are available to assist you around-the-clock. Personalised support is available by phone, e-mail or fax to:

- Help you find health care
- Answer your questions about claims, benefits and cover levels
- Process claims in many languages

## International Health Advisory Team

At the heart of our first-class service is the International Health Advisory Team (IHAT). IHAT is made up of a clinical staff that's trained to support you in meeting your health care needs.

IHAT is your single point of contact for a wealth of services and information, including:

- Pre-trip planning
- 24/7 support that's tailored to the individual's specific health needs
- Identification of providers and specialists
- Worldwide coordination of routine and urgent medical care
- Assistance with obtaining prescription medications and medical devices
- Coordinating second opinions for complex cases
- Coordination of care for return to home country after assignment completion
- Discharge planning
- Maternity management

Dial the International Member Service Center at the number on your member ID card to reach IHAT.

## Innovative tools and resources

With your cover, you'll have access to tools and resources via the Aetna International secure member website at [www.aetnainternational.com](http://www.aetnainternational.com) to help you to navigate your health care experience, including:

- **Doctor and medical facility search tool** that allows you to find screened and approved physicians and medical facilities
- **Online claims submission and claims lookup** to manage and keep track of claims status
- **Health and wellness information** to help you improve or maintain your health, given lifestyle, diet and/or conditions
- **Health and security news** with the latest risk ratings and security alerts
- **City profiles** inclusive of travel information such as vaccination requirements and emergency phone numbers
- **Drug and medical phrase translation** services with features that allow you to search for medication availability by country
- **Mobile doctor directory applications** helping you to find direct-settlement facilities in your city
- **More mobile applications coming soon**

### To register for the Aetna International secure member website:

1. Visit [www.aetnainternational.com](http://www.aetnainternational.com).
2. Click **Member** under **Secure login**.
3. Click on **Login/Register** under **Members on European, Asia Pacific, Middle East and Africa or Latin American and Caribbean based plans, start here**.
4. Click on the **Register** button and follow the on-screen prompts to set up a user name and password.

Once you've registered, you can enter your user name and password and click the Log In button to access the Aetna International secure member website in the future.



### **Reliable access to some of the world's leading health care professionals**

Aetna is committed to building strong and secure partnerships with health care professionals around the world — so that you have access to quality care when and where you may need it. That's why we have negotiated simplified prepayment procedures with thousands of medical facilities worldwide. Called "direct-settlement" arrangements, these agreements make accessing care easier and cover any eligible up-front costs associated with your care or treatment, such as planned inpatient treatment, a maternity stay, day patient services or high-cost outpatient services such as MRIs and CTs. This is a significant benefit if you're faced with a more expensive medical procedure.

For added convenience, we can also coordinate one-time arrangements if a health care professional is not in our direct-settlement database. We have a 95 percent success rate in negotiating these one-time arrangements. You also have the freedom to pay up front for care received at any health care professional worldwide, and submit a claim to us for reimbursement.

To find a direct-settlement facility in your region, visit the [Aetna International secure member website](#).



# Definitions

**Accident:** An unexpected, unforeseen and involuntary external event resulting in injury to a **member** and occurring whilst this **policy** is in force.

**Act of Terrorism:** An act, including, but not limited to, the use of force or violence and/or the threat thereof, of any person or **group(s)** of persons, whether acting alone, on behalf of, or in conjunction with any organisation(s) or government(s), committed for political, religious, ideological or ethnic purposes or reasons, including the intention to influence any government and/or to put the public or any section of the public in fear.

**Acute:** A **medical condition** which is brief, has a definite end point, and which **we**, on **advice** or **general advice**, determine can be cured by **treatment**.

**Advice:** Any consultation from a **medical practitioner** or **specialist**, including the issue of any prescriptions or repeat prescriptions.

**Appliances:** Devices and equipment when used as an integral part of a surgical procedure administered by a **medical practitioner** or **specialist**.

**Area of Cover:** The geographic area or specific country in which **you** may receive eligible **treatment** as stated on **your** benefits schedule and **certificate of insurance**.

**Benefits:** The insurance **cover** provided by this **policy** and any applicable endorsements shown in a **member's certificate of insurance**.

**Bodily Injury:** An injury that is caused solely by an **accident** and results in the **member's** dismemberment, disablement or other physical injury.

**Certificate of Insurance:** A schedule that provides **members** with information regarding the plan and **benefit** options elected by the **policyholder**, and lists those **members**, including any **dependants**, covered by the plan.

**Chronic:** A disease, illness or injury that has at least one of the following characteristics:

- It continues indefinitely and has no known cure
- It comes back or is likely to come back
- It is permanent
- **Members** need to be rehabilitated or specially trained to cope with it
- It needs long-term monitoring, consultations, checkups examinations or tests.

**Coinsurance:** The percentage of the total value of incurred expenses for which the **member** is responsible.

**Commencement Date:** The date shown on the **group policy**, on which the **policy** first came into effect.

**Conflict/Civil Unrest:** Any war, invasion, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege or attempted overthrow of government or any **act of terrorism**.

**Congenital Anomaly:** Any genetic, physical or (bio)chemical defect, disease or malformation (except **hereditary medical conditions**), which is due to an influence during gestation up to birth, and which may or may not be obvious at birth.

**Continuous Transfer Terms:** The acceptance by **us** of **your** original **date of entry** as shown by **your** current **policy** will be applied to **your** **policy** with **us**. **We** will maintain **your** existing underwriting or special acceptance terms, as offered by **your** existing **policy**, such as any moratoria or specific exclusions and **your** **policy** with **us** will be governed by the terms and conditions of **our** **policy**. Any transfer will be subject to no enhanced **benefits** being provided. **We** reserve the right at all times to decline a **continuous transfer terms** request without giving any reason or impose/include additional exclusions.

**Copay Per Visit:** The amount that would normally be paid by the **member** to the **provider** when receiving **treatment** in the **direct settlement network**. Each visit shall mean for each consultation.

**Country(ies) of Nationality:** The country (or countries) for which **members** hold a valid passport(s).

**Country of Residence:** The country in which **members** habitually reside (for a period of no less than six months per **period of cover**) at the time this **policy** is first taken out or at each subsequent **renewal date**.

**Cover:** Benefits provided to the **members** of a **group** plan.

**Date of Entry:** The date shown on the **certificate of insurance** on which a **member** was included under this **policy**.

**Day Patient:** A **member** who is admitted to a **hospital** bed but does not stay overnight.

**Deductible:** An amount that **we** may deduct from our reimbursement to **you**, equivalent to any copay or **coinsurance** that would normally be paid to the **provider** when receiving **treatment** in the **direct settlement network**.

**Dental Practitioner:** A person who is licensed by the relevant licensing authority to practice dentistry in the country where **dental treatment** is given.

**Dependants:** One spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with the **employee**, or 26 years old if in full-time education, at the **date of entry** or any subsequent **renewal date**. The term partner shall mean husband, wife or the person permanently living with the **employee** in a similar relationship. All **dependants** must be named in the **certificate of insurance**.

**Direct Settlement:** When **your** bill is settled directly by **us** either because the **provider** is contracted to our **direct settlement network** or because we have received and agreed to make a one time **direct settlement**.

**Direct Settlement Network** (Only available in certain countries): The medical **providers** where **members** are able to obtain **treatment** for valid **medical conditions** and where the expenses will be settled directly by **us**. **Members** are still responsible for any copay, **coinsurance**, **excess** or

**deductible** applicable, which must be settled directly with the medical **providers** at the time of **treatment**.

**Please Note:** Where **members** receive **treatment** for a **medical condition** that is not covered within the terms of the **policy**, the **member** remains liable for the costs of such **treatment**, which must be settled in full upon request. Failure to act accordingly will result in the suspension or cancellation of **your cover** under the **group plan**, without refund of premium.

**Drugs and Dressings:** Essential drugs, dressings and medicines prescribed by a **medical practitioner** or **specialist** and which are not available without prescription.

**Elective:** Planned **treatment** that is **medical necessary**, but which is not required in an **emergency**.

**Emergency:** A sudden, serious, and unforeseen **acute medical condition** or injury requiring immediate medical care.

**Employee:** A person employed by the **plan sponsor** and eligible for **cover** under its **group plan**.

**Evacuation:** Where **treatment** is not available at the place of the incident, the costs incurred in moving a **member** from the place of incident to the nearest country with appropriate medical facilities, as determined by the attending **medical practitioner** or **specialist** in conjunction with **our** medical advisors. All airline tickets are limited to economy class.

**Excess:** The amount payable by a **member** in respect of expenses incurred before any **benefits** are paid under the **policy**, as specified in their **certificate of insurance**.

**Expatriate:** Any persons living or working outside their country of citizenship, for a period exceeding six months per **period of cover**.

**General Advice:** Advice from the relevant professional body to establish medical practice and/or established medical opinion in relation to any **medical condition** or **treatment**.

**Group:** An aggregate that is comprised of a minimum of three employees of the **plan sponsor**.

**Group Administrator:** A person authorised to act on behalf of the **group**.

**Hereditary:** Transmitted from parents to offspring; inherited.

**Hospice:** A facility that provides **palliative treatment** and does not provide a cure.

**Hospital:** An establishment that is legally licensed as a medical or surgical **hospital** under the laws of the country in which it is situated.

**Inpatient:** A **member** who stays in a **hospital** bed and is admitted for one or more nights solely to receive **treatment**.

**Local National:** Any persons living or working in their country of citizenship, for a period exceeding six months per **period of cover**.

**Medical Condition:** Any injury, illness or disease, including psychiatric illness.

**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 who is licensed by the relevant authority to practice medicine in the country where the **treatment** is given.

**Medically Necessary:** A medical service or **treatment**, which in the opinion of a qualified **medical practitioner** is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the **member's** condition or the quality of medical care rendered.

**Member/Insured Person/You/Your:** A person who is employed by a **plan sponsor**, or is a covered **dependant** of an **employee**, and benefits from a **group plan** selected by the **policyholder**.

**Near Relative:** Spouse, child, brother, sister, parents, parents-in-law, sister-in-law and brother-in-law.

**New Born:** A baby who is within the first 16 weeks of its life following delivery.

**Organ Transplant:** The replacement of vital organs (including bone marrow) as a consequence of an underlying **medical condition**.

**Outpatient:** A **member** who receives **treatment** at a recognised medical facility, but is not admitted to a **hospital** bed as an **inpatient** or **day patient**.

**Palliative Treatment:** Any **treatment** given, on **advice** or **general advice**, for the purpose of offering temporary relief of symptoms. **Palliative treatment** is not given to treat the underlying **medical condition** causing the symptoms. For the purposes of this **policy**, **palliative treatment** will include renal dialysis.

**Period of Cover:** The **period of cover** set out in the **certificate of insurance**. This will be a 12 month period starting from the **date of entry** or any subsequent **renewal date**, as applicable.

**Plan Sponsor:** A company or **group** that enters into an insurance arrangement with **us**.

**Policy:** The **group health insurance policy**, **our** contract of insurance with the **policyholder** providing **cover** as detailed in the **policy documentation**.

**Policy Documentation:** The set of **policy** documents that form a contractual agreement between **us** and the **policyholder**. These documents include any application forms, the group formation form, the certificate of insurance, the member handbook, and any other supporting documentation.

**Policyholder:** The entity that **we** have contracted with and to which **we** have issued a **group policy** for the provision of **group insurance benefits**.

**Private Room:** Single occupancy accommodation in a private **hospital**.

**Provider:** A **provider** who is legally licensed to supply **treatment** in the country in which it is provided.

**Provider Network:** A supplier of **treatment** participating in the **direct settlement network**.

**Qualified Nurse:** A **qualified nurse** whose name is currently on any register or roll of nurses, maintained by any Statutory Nursing Registration Body within the country in which he/she is resident.

**Reasonable and Customary Charges:** The average amount charged in respect of valid services or **treatment** costs, as determined by **our** experience in any particular country, area or region and substantiated by an independent third party, being a practicing surgeon/physician/**specialist** or government health department.

**Rehabilitation:** Assisting a **member** who, following a **medical condition**, requiring physical therapy and assistance in independent living to restore them, as much as Medical Necessary or practically able, to the position in which they were in prior to such **medical condition** occurring.

**Related Condition:** Any injuries, illnesses or diseases are **related conditions** if **we**, on **general advice**, determine that one is a result of the other or if each is a result of the same injury, illness or disease.

**Renewal Date:** The anniversary of the **commencement date** of the **policy**.

**Semi-Private Room:** Dual occupancy accommodation in a private **hospital**.

**Specialist:** A registered **medical practitioner** who currently holds a substantive consultant appointment in that specialty, which is recognised as such by the statutory bodies of the relevant country.

**Treatment:** Surgical, medical or other procedures, the sole purpose of which is the cure or relief of a **medical condition**.

**Underwriters:** The carrier of risk and payer of **benefits** as indicated in the **policy documentation** and **certificate of insurance**.

**Ward Room:** Accommodation in a private **hospital** where the patient is sharing the room with more than one other patient.

**We/Our/Us:** Aetna International on behalf of **underwriters** as detailed in **your certificate of insurance**.



# General conditions

## 1. Policy

This insurance contract consists of the **policy (group policy)**; the group formation form or other application form; the current rates on file with the **policyholder**; and the **policy documentation**, including the **certificate of insurance**, benefits schedule and member handbook. The rights of the **policyholder**; any insured **employee**; or any beneficiary will not be affected by any provision other than the one described above.

## 2. Language

This **policy** may only be completed in English.

## 3. Eligibility for Cover

New applicants will be eligible for **cover** up until the age of 65.

Any **employee** or **dependant** not enrolled within 30 days of eligibility will be subject to individual underwriting.

**New born** children will be accepted for **cover** (subject to the limitations of the **new born benefit**) from birth. Acceptance of **new born** babies is subject to written notification within 30 days of birth and receipt of the full premium within a further 30 days following notification.

Children who are not more than 18 years old residing with the **employee**, or 26 years old if in full-time education, at the **date of entry** or at any subsequent **renewal date**, will be accepted for **cover** as **your dependants**. Children will not be accepted for **cover**, unless on a **policy** with a legal parent or guardian and subject to the identical **benefits** applying to all parties.

A declaration of health is required with respect to all **dependants** who are born following assisted conception. **We** reserve the right to reject any application without giving any reason.

## 4. Termination of Cover

Cover may end if:

- i) **You** employer cancels or terminates the **group** plan.
- ii) **You** voluntarily stop **your cover** under the **group** plan.
- iii) **You** are no longer eligible for **cover** (e.g., **your** employment stops.)
- iv) **You** exhaust the maximum annual aggregate **benefit** under the **group** plan.
- v) **You** fail to reimburse **us** within 14 days of receipt of notice that **we** have made payment for **treatment** of a **medical condition** not covered within the terms and conditions of the **group** plan.

## 5. Cover

**We** will pay the insurance **benefits** (specific **benefits** will not exceed the corresponding payment limit and the total amount of **benefits** will not exceed the mutually agreed maximum insured amount of the **policy**) as follows: all costs incurred must be **medical necessary** and subject to **reasonable and customary charges**.

The insurance contract will provide **cover** for **treatment** given during the current **period of cover**.

## 6. Period of Cover

**Your** plan is in force for the **period of cover** noted in **your certificate of insurance**. The **period of cover** is annually renewable thereafter.

## 7. Policy Documents

**We** will provide a **certificate of insurance** for each **member** and any eligible **dependants** benefitting from **cover** under this **policy**.

## 8. Contribution

If there is any other insurance in place covering any of the same **benefits**, **you** must disclose the same to **us** and **we** shall not be liable to pay or contribute more than **our** proper proportion. If it is found that **you** were repaid for all or some of those expenses by another source, including any other insurance **policy**, **we** will have the right to a refund from **you**. Where necessary, **we** retain the right to deduct such refund from any impending or future claim settlements.

## 9. Change of Risk

The **policyholder** or **insured person** must inform **us** as soon as reasonably possible of any material changes that affects information given in connection with the application for **cover** under this **policy**. **We** reserve the right to alter the **policy** terms or cancel **cover** for an **insured person** following a change of risk.

## 10. Declaration of Material Facts

All material facts (e.g., a pre-existing health condition or involvement in a hazardous activity) that may affect **our** assessment and consideration of an application should be declared. Failure to do so may invalidate **your cover** under a **group** plan. If **you** are in doubt whether a fact is material then it should be disclosed.

## 11. Break in Cover

Where there is a break in **cover**, for whatever reason, **we** reserve the right to reapply exclusion clause 1 in respect of pre-existing **medical conditions**.

## 12. Claim Notification

Please ensure that **your** claim form is completed in full and returned within 180 days of the date of **treatment**. Refer to the claims section on page 12 for more detail.

## 13. Payment of Claims

If **we** think that the evidence of the claim submission and the information provided is incomplete, then **you** will be informed promptly of the required supplementary information.

Providing all relevant information is submitted to support **your** claim, **we** will reimburse **you** by the payment method of **your** choice as stated on **your** claim form.

#### 14. Fraudulent or Unfounded Claims

If any claim is in any respect fraudulent or unfounded, all **benefits** paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable. In addition, all **cover** in respect of the **insured persons** shall be cancelled void from the **date of entry**.

#### 15. Applicable Law

The law applicable to this **policy** shall be specified in the **certificate of insurance**. If no law is specified, then the **policy** shall be construed according to the laws of England, and shall be subject to the non-exclusive jurisdiction of the courts of England and Wales.

#### 16. Subrogation

The **policy** shall be subrogated to all rights of recovery that **insured persons** have against any other party with respect to any payment made by that party to **insured persons** due to any injury, illness or **medical condition insured persons** sustain to the full extent of the **benefits** provided or to be provided by the **policy**. If **insured persons** receive any payment from any other party or from any other insurance **cover** as a result of an injury, illness or **medical condition**, **we** have the right to recover from, and be reimbursed by them, for all amounts **we** have paid and will pay as a result of that injury, illness or **medical condition**, from such payment, up to and including the full amount received.

**We** shall be entitled to full reimbursement from any other party's payments, even if such payment will result in a recovery that is insufficient to fully compensate the **insured person** in part or in whole for the damages sustained.

**Insured person's** are required to fully cooperate with **us** in **our** efforts to recover any payments made including any legal proceedings that **we** may conduct and proceed with on their behalf at **our** sole discretion. **Insured person's** are required to notify **us** within 30 days of the date when any notice is given to any party, including an insurance company or lawyer, of the **insured person's** intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or **medical condition** sustained by the **insured person**. Other than with **our** written consent, **insured person's** have no entitlement to admit liability for any eventuality or give promise of any undertaking that is binding upon them. In the event that any claim or dispute is made in respect of this subrogation or any part thereof, including, but not limited to, any right of recovery provision which is ambiguous or questions arise concerning the meaning or intent of any of its terms, **we** shall for the avoidance of doubt have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

#### 17. Family/Dependant Cover

**Employees** and their **dependants** are required to be covered under the same **group** plan with identical **benefits**.

#### 18. Membership Applications

**We** maintain the right to ask the **plan sponsor** to provide proof of age and/or a declaration of health of any person included in his/her application. **We** reserve the right to apply additional options, exclusions or premium increases to reflect any circumstances the **plan sponsor** or **insured person** advises in their application form or declares to **us** as a material fact.

#### 19. Medical Evaluation

**We** reserve the right to request further tests and or evaluation where **we** have decided that a condition being claimed for may be directly or indirectly related to an excluded condition.

#### 20. Waiver

**Our** deviation from specific terms of the **policy** **documentation** hereunder at any time shall not constitute a waiver of **our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums or **benefits**. This applies whether or not the circumstances are the same.

#### 21. Our Right of Cancellation

In the event of any non-payment of premium by the **policyholder**, **we** shall be entitled to cancel the **policy** and any related **cover/plan**. **We** may, at **our** discretion, reinstate **cover** if the full premium is subsequently paid, though terms of **cover** may be subject to variation.

**We** may at any time terminate a **member's cover** if he/she or the **policyholder** has at any time:

- i) Mised **us** by misstatement
- ii) Knowingly claimed **benefits** for any purpose other than as are provided for under this **policy**
- iii) Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to **our** detriment
- iv) Otherwise failed to observe the terms and conditions of this **policy** or failed to act with good faith.

#### 22. Liability

**Our** liability shall cease immediately upon termination of the **policy** for whatever reason, including without limitation non-renewal and non-payment of premium.

#### 23. Parties to the Contract

The only parties to this contract are the **policyholder** and **us**.

#### 24. Currency

The monetary limits applicable to this **policy** will be expressed in the same currency as the insurance premium. Claims paid in a local currency will be converted at the rate of exchange quoted on [www.oanda.com](http://www.oanda.com) at the date the **insured person** received **treatment**.

## **25. Conflict or Civil Unrest, Chemical or Radioactivity Contamination**

**Treatment** and expenses directly or indirectly arising from or required as a consequence of **conflict** or **civil unrest**, chemical or radioactivity contamination from any chemical and nuclear material or from the combustion of nuclear fuel or any **related condition** are covered by this **policy** provided the **member**:

- i) Is not an active participant in any **conflict** or **civil unrest**
- ii) Is not involved in any illegal activities which directly or indirectly lead to injury or illness
- iii) Does not knowingly enter or remain in a country, region or location where there is **conflict**, **civil unrest**, natural disaster, chemical, nuclear or radioactive contamination
- iv) Does not intentionally put him/herself at risk of illness or injury resulting from **conflict**, **civil unrest**, natural disaster, chemical, nuclear or radioactive contamination
- v) Is not a member of any armed forces, security services including personal protection, chemical, nuclear or radioactive contamination cleaning crews of any kind or type (including governmental workers or private teams)

Based on the information provided at inception or renewal Aetna will assess the current, future or developing risk exposure of **members** located in high risk areas and will notify the **policyholder** of any actions, limitations, exclusions or premium loadings required to ensure on going **cover** and **member** safety.

# Exclusions

**1.** Any **medical condition** or **related condition** for which **you** have received **treatment**, had symptoms of, and to the best of **your** knowledge existed or **you** sought **advice** for prior to **your date of entry** (pre-existing **medical condition**), except where such **medical conditions** have been declared to **us** and accepted in writing. After two years of continuous membership, any pre-existing **medical conditions** (and **related conditions**) will become eligible for **benefit** provided (in respect of that condition) that **you** have not during that period:

- i) Consulted any **medical practitioner** or **specialist** for **treatment** or **advice** (including checkups).
- ii) Experienced further symptoms.
- iii) Taken medication (including drugs, medicines, special diets or injections).

**2.** **Chronic** supportive **treatment** of renal failure, including dialysis unless the **Chronic Conditions benefit** is part of **your** plan or has been purchased.

We will, however, pay for the cost of renal dialysis incurred:

- i) Immediately pre- and post-operatively.
- ii) In connection with **acute** secondary failure when dialysis is part of intensive care.

**3.** **Treatment**, which we determine on **general advice**, is either experimental or unproven.

**4.** **Hereditary medical condition(s)**.

**5.** **Congenital anomalies** where symptoms exist or where **advice** has been sought prior to the **member's date of entry** unless the **member** is an infant up to the age of 12 months. This exclusion is removed if the **benefit** for **congenital anomalies** including pre-existing conditions has been purchased.

**6.** Preventive medicines, and routine tests and physical examinations by a **medical practitioner**, including gynaecological investigations, unless the **Wellness benefit** or **Wellness Preventive Screening benefit** has been purchased. Normal hearing tests are excluded unless the **Hearing benefit**, or **Wellness Hearing and Vision module** has been purchased.

**7.** Non-medical/natural degenerative eye defects, including but not limited to, myopia, presbyopia and astigmatism and any corrective surgery for non-medical/natural degenerative sight defects. Normal eye tests are excluded unless the **Vision Care benefit** has been purchased.

**8.** **Rehabilitation** except as expressly provided under the **benefit** for **Inpatient Care, Rehabilitation**.

**9.** **Treatment** received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments, or a **hospital** where the **hospital** has effectively become the **member's** home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

**10.** **Cosmetic treatment**, and any consequence thereof.

**11.** **Treatment** for weight loss or weight problems whether or not preceding or as a consequence of a psychiatric condition and any associated **treatment** costs consequent of cosmetic surgery or arising as a result of an eating disorder or weight problem, including any required psychiatric **treatment** where the psychiatric condition is a **related condition** to the eating disorder.

**12.** Alternative therapy, including, but not limited to, hypnotherapists and lactation examiners.

**13.** Costs incurred in connection with locating a replacement organ or any costs incurred for removal of the organ from the donor, transportation costs of same and all associated administration costs.

**14.** Voluntary caesarean section costs or **medically necessary** caesarean section costs due to any previous non-emergency caesarean sections undertaken, unless the **benefit** for Routine Maternity has been purchased.

**15.** Pregnancy terminations on non-medical grounds, antenatal classes or midwifery costs when not associated with delivery.

**16.** **New born** neo-natal care costs are excluded unless the **benefit** for Routine Pregnancy has been purchased, which provides **cover** for the first 24 hours following birth, whilst the mother (being and insured **member**) receives **treatment** as an **inpatient**.

**17.** **Treatment** directly or indirectly arising from (or required in connection with) male and female birth control, sterilisation (or its reversal). Infertility **treatment** (assisted conception) is excluded unless the **benefit** for infertility **treatment** has been purchased. Any complications of pregnancy and routine pregnancy costs resulting from infertility **treatment** (assisted conception) are excluded except where the **benefit** for Routine Pregnancy has been purchased.

**18.** **Treatment** of impotence or any **related condition** or consequence thereof.

**19.** **Treatment** directly or indirectly associated with a sex change and any consequence thereof.

**20.** Venereal disease or any other sexually transmitted diseases or any **related condition** except for those payable under the **AIDS benefit**.

**21.** Costs in respect of a psychotherapist or psychologist, (unless referred to by and under the direct control of a psychiatrist), a family therapist or bereavement counselor.

**22.** **Treatment** for learning difficulties, hyperactivity, attention deficit disorder, speech therapy and developmental, social or behavioural problems in children (except as covered under the **Wellness benefit**).

**23.** **Treatment** for alcoholism, drug or substance abuse or any addictive condition of any kind and any injury or illness arising directly or indirectly from such abuse or addiction. For **members** residing in the Czech Republic, we cover the cost of

**treatment** for **accidents** resulting from the consumption of drugs or alcohol in line with minimum health requirements provided that no illegal acts have taken place.

**24.** Suicide or attempted suicide, **bodily injury** or illness, which is willfully self-inflicted or due to negligent or reckless behaviour.

**25.** Any injury sustained directly or indirectly as a result of the **member** acting illegally or committing or helping to commit a criminal offence.

**26.** Costs and expenses incurred where a **member** has travelled against medical **advice**.

**27. Evacuation** expenses (unless pre-authorized by **us**). Air rescue, sea rescue or mountain rescue costs (unless incurred at recognised ski or similar winter sports resorts).

**28.** Travel and accommodation costs unless specifically agreed by **us** in writing prior to travel. No travel and accommodation costs are payable where **treatment** is obtained solely as an **outpatient**, including the costs of a hired car.

**29. Treatment** for sleep related breathing disorders, including snoring, fatigue, jet lag or work-related stress or any **related condition**.

**30.** Dietary supplements and substances that are available naturally and that can be purchased without prescription, including, but not limited to, vitamins, minerals and organic substances. **We** will however pay for prescribed pre natal vitamins under the Routine Pregnancy **benefit** if purchased.

**31.** Home visits by a **medical practitioner, specialist** or **qualified nurse** unless specifically agreed by **us** in writing prior to consultation.

**32.** Complications of pregnancy costs arising during the first 12 months from the **commencement date** or **date of entry**, whichever is the later unless underwriting is on a Medical History Disregard Basis or the **benefit** for Complications of Pregnancy with no wait period has been purchased.

**33.** External prostheses, including their maintenance or fitting, any hearing aids or other equipment, medical or otherwise except as is specified in the **benefit** for Durable Medical Equipment Prosthetic and Orthotic Supplies (DMEPOS), and the Hearing or Vision **benefits** if purchased.

**34.** Hazardous activities, including playing professional sports and/or taking part in motor sports of any kind; mountaineering, including potholing, spelunking or caving; high-altitude trekking over 2,500 metres; skiing off-piste or any other winter sports activity carried out off-piste; and arctic or antarctic expeditions.

**35.** All **benefits** are excluded unless they appear on **your** benefits schedule.



# 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.

## 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 **treatments**:

- 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 copies of original receipts to initiate the claim process and to facilitate the assessment of **your** claim (i.e., if **you** submit claims via fax or e-mail); however, we require that you send the originals before any claims payment is made by **us**.

The International Bank Account Number (IBAN) will be mandatory for all bank transfer transactions in the United Arab Emirates (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 **treatments**:

- i) Planned **inpatient** or **day patient** treatment (hospitalisation)
- ii) Any pregnancy or childbirth **treatment**
- iii) Planned surgery

- iv) Home nursing charges
- v) Planned MRI, PET and CT scans
- vi) Infertility **treatment** (if purchased)
- vii) **Outpatient** psychiatric

We also require pre-authorisation when seeking emergency evacuation.

## 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 planned **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 practitioners** 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 condition** and **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 USA.

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 USA, 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. **Our** claims department will determine what portion of the invoice is applied to **your excess** and which portion is payable by **us**. 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

To ensure prompt settlement of claims, please take **your** claim form with **you** in order for it to be completed by the treating practitioner or **specialist**.

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

For those in the relevant participating countries, **we** have arranged a **direct settlement network** enabling **members** to obtain **outpatient treatment** (as defined in the **certificate of insurance**) at a number of selected medical centres where all eligible **treatment** charges will be paid directly by **us**.

When seeking eligible **outpatient treatment** at any of the participating centres, it is important that **you** present **your** personal Aetna International membership card to the medical centre/service **provider** before **treatment** begins in order to ensure that **you** are not asked to settle any **treatment** costs. **You** may be responsible for paying a per visit copayment to the **provider** but this will be clearly shown on **your** membership card.

- Present **your** Aetna International membership card to the medical centre/**provider** on arrival.
- Have a second form of identification available should it be required by the reception staff.
- Check the claim form that the medical centre will provide after **your treatment** and sign it to confirm that **you** have received the **treatment** stated.
- Settle any charges made by the medical centre, which relate to either items not covered or ineligible **treatment** that **you** may have received.

**IMPORTANT:** Please remember that **your** Aetna International membership card should not be used to obtain **treatment** that is excluded from **cover**.

### 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.

### One time Direct Settlement

Exceptions may be made for high cost procedures. In this case, **members** are required to contact **us** prior to receiving **treatment**, in order for **us** to attempt to arrange direct payment with the medical facility concerned. Please note that not all medical facilities will accept direct payment from **us**. In these instances, **you** will be required to settle the bill and submit a claim to **us** for reimbursement.

### 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 area **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 USA.

Where **your policy** allows, **outpatient** services and **treatment** received within **our provider network** can be billed to **us** directly. Prior to seeking **treatment**, **we** recommend that **you** contact our Member Services team who can check the location of **your** nearest participating **provider**.

**Members** are required to show their membership card to the **provider** who will contact **us** to confirm direct billing. This may not happen immediately and, should **you** be asked to pay for the **treatment**, please ensure **you** state clearly to the facility that **you** wish to have **your** bill settled directly by **us**, and for them to contact the number on **your** Aetna International membership card.

**Our** claims department will process the claim according to the applicable portion payable by **us**, taking into account **your excess** and any **coinsurance** applicable. Once **our** portion is paid, **we** will send both **you** and the **provider** an explanation of benefits (EOB) with details of settlement and a statement of what **you** are responsible for.

# Complaint procedures

## IF YOU WISH TO MAKE A COMPLAINT

Write to: Aetna Global Benefits Limited  
P.O. Box 6380  
Dubai  
United Arab Emirates

Telephone: +971 4 438 7600

Fax: +971 4 428 7101

Email: [MEAServices@aetna.com](mailto:MEAServices@aetna.com)

## Summary of our complaint handling procedures

Complaints and Appeals will:

- Be acknowledged promptly confirming who will be responsible for the investigation of **your** complaint and how it will be conducted
- Be investigated competently, efficiently and impartially ensuring that **we** provide updates on progress
- Be assessed fairly, consistently and promptly
- Be responded to within eight weeks; **you** will receive either a letter explaining the status of **your** complaint or a final response outlining the determination of the investigation

## Contact us today

Members can reach us at the contact information found on their membership ID card.

## Stay connected to Aetna International

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