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Eligibility will not extend in any event to any applicants with a country of residence, at the time of application for enrollment or any subsequent renewal date, of the USA or Bermuda, and all coverage shall terminate if you reside or come to reside for 90 consecutive days during any period of coverage in either Bermuda or the USA.

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Definitions

To help you understand your policy, we defined specific words and phrases in this section. These appear throughout this document.

Accident

An unexpected, unforeseen and involuntary external event resulting in injury occurring while your 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 or on behalf of or in conjunction with any organization(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 that is brief, has a definite end point and which we, on advice or general advice, determine responds to and can be cured by treatment.

Advice

Any consultation by a physician or specialist physician including the issue of drugs and dressings or repeat prescriptions.

Appliances

Devices and equipment when used as an integral part of a surgical procedure administered by a physician or specialist physician.

Application for enrollment

The form completed and executed by you and submitted to us for consideration and approval of your enrollment and the enrollment of any other eligible person listed on the application for enrollment.

Benefits

The insurance coverage provided by this policy and any extensions or restrictions shown in the policy schedule or in any endorsements (if and where applicable).

Bodily injury

Injury that is caused solely by an accident and results in the insured person's dismemberment, disablement or other physical external injury.

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

- You need to be rehabilitated or specially trained to cope with it
- It needs long-term monitoring, consultations, checkup examinations or tests

Coinsurance

The percentage of the total value of the incurred expenses you are responsible for each period of coverage, exclusive of the deductible.

Commencement date

The date shown on the policy schedule on which coverage under the insured person's certificate, or in respect of a particular benefit, commences. For the purpose of this policy, coverage commences from 12:01 A.M. on the date shown on the policy schedule.

Congenital anomaly

A genetic, physical or (bio) chemical defect, disease or malformation, which may either be hereditary/familial or due to an influence during gestation up to birth, and which may or may not be obvious at birth.

Convalescence

Physical, occupational or speech therapy, vocational guidance, independent living advice and exercises, retraining, educational pursuits and other services given to an insured person following an eligible medical condition, to assist the insured person, as much as is reasonably possible, to readapt to life in the community and/or to restore him/her to the state of health he/she enjoyed prior to such medical condition occurring.

Convalescent facility

An institution licensed to provide 24 hour chargeable qualified nurse care, through supervision by a full-time physician, and physical restoration services to help patients achieve self care in daily living activities. This does not extend to any institution providing long term care for the elderly, custodial or educational care or for care of mental disorders.

Country of nationality

For the purpose of this policy, this will be the country to which insured person holds a passport.

Country of residence

The country in which the insured person has habitual residence (residing for a period of no less than 6 months per period of coverage) at the date of entry of this certificate. Members living in the USA or Bermuda are considered residents after living in the country for 90 consecutive days.

Date of entry

The date shown on the policy schedule on which an insured person was first included under the policy.

Day patient

Treatment in a medical facility where the patient is admitted to a bed but does not stay overnight.

Deductible

The amount payable by an insured person in respect of expenses incurred for treatment, before any benefits are paid under the policy for each period of coverage, exclusive of coinsurance.

Dental practitioner

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

Drugs and dressings

Essential drugs, medicines and dressings prescribed by a physician or specialist physician and which are not available without prescription.

Eligible person

A person that satisfies the requirements for enrollment. An eligible person is one who is either your spouse or adult partner, or your unmarried children who are not more than 18 years old and residing with you, or your unmarried children who are not more than 25 years old if in full time education, at the date of entry or at any subsequent renewal date. Children under the age of 18 not residing with you will be accepted for coverage providing the application is signed by a legal parent or guardian. The term partner shall mean husband, wife or the person permanently living with you (whether or not of the same sex) in a similar relationship. All eligible persons must be named as insured persons in the policy schedule.

Emergency

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

Evacuation

Costs incurred in moving an insured person from the place of incident to the nearest country with an appropriate medical facility, as determined by the attending physician in conjunction with our medical advisors. All airline tickets will be limited to economy class.

Expatriate

Any persons living or working outside of the country for which they hold a passport, for a period exceeding 6 (six) months per period of coverage.

General advice

Notice from the relevant professional body as to established medical practice and/or established medical opinion in relation to any medical condition or treatment.

Hereditary

Transmitted from parents to offspring, inherited and which presents symptoms at birth.

Home health care

Treatment made in the home of the insured person.

Home health care provider

A health care worker with sufficient training and qualifications to comply with any relevant regulation within the country in which the treatment is undertaken and who provides basic nursing care. In the USA, such health care workers should be LPN or RN qualified.

Hospice

A medical facility providing inpatient hospice care to patients with a terminal illness.

Hospice care

Palliative treatment and supportive care given to patients diagnosed by a physician or specialist physician as having a terminal illness.

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

An insured person who is admitted to a bed in a medical facility for one or more nights solely to receive treatment.

Insured person/you/your

The policyholder and/or the eligible persons named on the policy schedule.

Medical condition

Any injury, illness or disease including psychiatric illness.

Medical facility

A hospital, hospice or convalescent facility that:

- a) Provides 24 hour nursing care by qualified nurses
- b) Is supervised full-time by a physician
- c) Has at least one physician on call at all times
- d) Keeps a complete medical record of each patient
- e) Has a full-time administrator
- f) Meets any licensing or certification standards of the country where it is situated
- g) Is a fee charging establishment

Medically necessary

A medical service or treatment, which, in the opinion of a qualified physician, 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 insured person's condition or the quality of medical care rendered.

Network provider

A health care provider that has contracted to supply services for a pre-agreed charge and is included in our directory of medical facilities named as preferred care providers. You are entitled to ask us for a list of preferred care providers.

New born

A baby who is within the first 16 weeks of its life following delivery.

Occupational therapist

A person who is registered as an occupational therapist and licensed to practice in the country where treatment is given.

Outpatient treatment

An insured person who receives treatment by a physician or specialist physician but is not admitted to a bed in a medical facility.

Palliative treatment

Any treatment, which is on advice or general advice, for the purpose of offering temporary relief of symptoms and where it is not given to cure the medical condition causing the symptoms.

Period of coverage

The period of coverage set out in the policy schedule. This will be a twelve month period starting from the commencement date or any subsequent renewal date.

Physician

A person who has attained primary degrees in medicine or surgery by attending a medical school recognized by the World Health Organization and who is licensed by the relevant authority to practice medicine in the country where the treatment is given. This includes, but is not limited to, a general physician, family practitioner and pediatrician.

Physiotherapist

A person who is registered as a physiotherapist and licensed to practice in the country where treatment is given.

Policy

Our contract of insurance with you providing coverage as detailed in this document. The application for enrollment form and policy schedule form part of the contract and must be read together with the policy.

Policy schedule

The schedule giving details of the policyholder and the insured persons, policy details and endorsements (if applicable).

Private room

Single occupancy accommodation in a private hospital.

Prosthesis

An artificial body part. Under this policy, the definition of prosthesis will be limited to an artificial limb or eye.

Psychiatric physician

A physician specializing in psychiatry or who has the training or experience recognized in the country in which he/she is resident to perform the required evaluation and treatment of psychiatric illness.

Qualified nurse

A qualified and licensed resident or daily nurse whose name is on any register or roll of nurses, maintained by any statutory 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 in our experience in a particular country, area or region and substantiated by an independent third party, being a practicing physician, specialist physician or government health department.

Related condition

Any medical condition is a related condition if we, on general advice, determine that one is the direct result of the other or if each is a result of the same injury, illness or disease.

Renewal date

The annual anniversary of the commencement date.

Room and board

Charges made by a medical facility for the provision of a room, bed and other necessary services made on a daily or weekly standard private room or semi-private room rate, as specified in the Schedule of Benefits.

Semi-private room

Dual occupancy accommodation in a private hospital.

Specialist physician

A registered physician who:

- a) Currently holds a substantive consultant appointment in that specialty in a medical facility;
- b) Currently holds a substantive consultant appointment which we on professional advice or general advice accept as being of equivalent professional status;
or
- c) Is recognized as such by the statutory bodies of the relevant country.

Terminal illness

A medical prognosis of six (6) months or less to live.

Treatment

Surgical, medical or other procedures to cure or relieve a medical condition.

We/our/us

Aetna Life & Casualty (Bermuda) Ltd, trading as Aetna International.

Benefits

We will provide insurance within the terms of the policy, in respect of a medical condition (including those as a result of an accident) that first occurs during the period of coverage.

The policy provides for medical expenses insurance only and is not insurance for the disease or injury itself. No benefits are payable for treatment received before the date of entry, after the period of coverage has expired or after the coverage has terminated, even if the expenses were incurred as a result of an accident or medical condition which occurred, commenced or existed during the period of coverage.

The following benefits are covered up to the amounts shown in your Schedule of Benefits and are applied per insured person per period of coverage, subject to the payment of all deductible(s) and coinsurance as set out in section headed deductible and coinsurance in this policy and/or as stated in the Schedule of Benefits. All benefits are subject to all medical expenses covered being no more than reasonable and customary charges.

1. Physician and specialist physician fees

- a) Physician and specialist physician fees including consultations.
- b) Diagnostic and surgical procedures, including pathology, X-rays, MRI, MRA/MRS, PET and CT scans.
- c) Anesthetist fees.
- d) Physical therapy on referral by a physician to a physiotherapist or occupational therapist. A referral letter from a physician must be submitted with the first claim for such treatment. Benefits will be restricted to 10 sessions without a written report. After this time a written report must be produced and submitted to us for review by the physician before treatment can continue.

2. Medical facility and home health care charges

- a) Hospital charges:
 - i) Operating room fees and other charges incurred for the treatment of a medical condition.
 - ii) Room and board costs and associated charges, including admittance to the intensive care unit, and charges for nursing by a qualified nurse.
 - iii) Charges for applicable service and supplies as set out in (i) and (ii) above for day patient and outpatient treatment.
- b) Convalescent facility charges:

Admission to a convalescent facility must follow treatment for a medical condition where the insured person was confined to a hospital as an inpatient for at least three consecutive days, and where a physician confirms in writing that convalescence is required. Admission to a convalescent facility must be made within 14 days of discharge from hospital.

Such treatment would cover:

 - i) Use of special treatment rooms.
 - ii) Physical, occupational or speech therapy fees.
 - iii) Other services usually given by a convalescent facility including qualified nurse care but not including private or special nursing or specialist physician services.
- c) Home health care charges:

Treatment if made in the home of the insured person.

Such treatment will cover:

 - i) Part-time or intermittent care by a qualified nurse.
 - ii) Part-time or intermittent services of a home health care provider.
 - iii) Laboratory services.

Home health care benefits are limited to the number of visits noted in the Schedule of Benefits. Each visit by a qualified nurse or home health care provider of up to 4 hours duration is considered as one visit. Each visit of more than 4 hours duration will be considered as two or more visits, each visit being deemed to compose of 4 hours of services provided. All treatment under this benefit is conditional upon precertification by us. Without our written consent prior to treatment, we will not be liable to pay any benefit.

d) Hospice care charges:

Treatment provided by a hospice for the care of an insured person with a terminal illness.

Such treatment will cover:

- i) Palliative treatment and other acute and chronic symptom management.
- ii) Medical social services under the direction of a physician or specialist physician.
- iii) Physiological and dietary counseling.
- iv) Consultation or case management services by a physician or specialist physician.
- v) Part-time or intermittent home health care provider services for up to 8 hours in any one day for outpatient care.

e) General charges applicable to all medical facilities:

- i) Room and board costs and associated charges
- ii) Drugs and dressings
- iii) Diagnostic X-ray and laboratory work
- iv) Anesthetics
- v) Oxygen and gas therapy

3. Drugs and dressings

Drugs, dressings, medicines and appliances prescribed by a physician or specialist physician.

4. Reconstructive surgery

Reconstructive surgery following an accident or following surgery for an eligible medical condition, provided such surgery is carried out at a medically suitable stage after the accident or surgery has occurred. Surgery must be carried out within 365 days from the date of the accident or medical condition subject to policy coverage being maintained throughout such period.

5. Accidental damage to teeth

Treatment initially received in an emergency room in a hospital within 7 days of incurring accidental damage

caused to sound, natural teeth that were firmly attached to the jaw bone at the time of injury, when given by a physician or dental practitioner.

Coverage is limited to:

- i) The first denture or fixed bridgework to replace lost teeth.
- ii) The first crown needed to repair each damaged tooth.

6. Emergency transportation

Transportation costs to and from a hospital by the most appropriate transport method (including licensed air ambulance but excluding all other forms of air transportation) in the event of an emergency where considered medically necessary by a physician or specialist physician. Costs for air ambulance, which have not been coordinated by us, are limited to US\$2,000 per incident.

7. Evacuation

Evacuation costs of an insured person in the event of emergency treatment not being readily available at the place of the incident, to the nearest appropriate medical facility, for the purpose of admission to a medical facility as an inpatient or day patient. Evacuation is subject to precertification by us prior to travel and certified instructions from the attending physician or specialist physician, including confirmation that the required treatment is unavailable in the place of incident. Extended to cover the costs for one other person to travel with the insured person, as escort, if medically necessary. Our medical advisors will decide the most appropriate method of transportation for the evacuation and the most appropriate medical facility to which you will be evacuated.

8. Additional travel expenses following evacuation

Travel costs:

- i) To and from medical appointments when treatment is being received as a day patient.
- ii) For an accompanying person to travel to and from the hospital to visit the insured person following admission as an inpatient
- iii) Non-hospital accommodation for immediate pre and post hospital admission periods provided that the insured person is within their convalescence period and under the care of a specialist physician.
- iv) Economy class airline ticket to return the insured person and one other person who has traveled as an escort to your country of residence or to the country where evacuation occurred.

9. Mortal remains

In the event of death from an eligible medical condition:

- i) Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence; or
- ii) Burial or cremation costs at the place of death in accordance with reasonable and customary practice.

10. External prostheses

The costs of any artificial eyes and limbs following treatment for an eligible medical condition or as a result of an accident.

11. Organ transplants

Covered transplants are:

- a) Heart
- b) Lung
- c) Heart/Lung
- d) Simultaneous pancreas kidney (SPK)
- e) Pancreas
- f) Kidney
- g) Liver
- h) Intestine
- i) Bone marrow/stem cell
- j) Multiple organs replaced during one transplant surgery
- k) Tandem transplant (stem cell)
- l) Re-transplant of same organ type within 180 days of the first transplant

12. Wellness benefit

The cost of one annual routine medical checkup and associated tests and the cost of medically necessary vaccinations or inoculations.

Such routine checkups/tests include:

- a) Blood and cholesterol checks
- b) Height/weight body mass index
- c) Resting blood pressure
- d) Urine analysis
- e) Cardiac examination
- f) Bilateral mammogram/breast examination
- g) Testicular/prostate examination/PSA/DRE Tests
- h) Exercise electrocardiogram (ECG)
- i) Well-baby checks including physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening at birth, immunizations, urine analysis, tuberculin tests and hematocrit, hemoglobin and other blood tests, including tests to screen for sickle hemoglobinopathy; all as recommended by a physician

or specialist physician. Limited to a maximum of six (6) consultations per new born per annum from birth until the dependent child reaches the age of 2 years.

- j) Routine gynecological tests, including Pap tests.

13. Colorectal screening

Deemed medically necessary due to:

- Being age 50 and over;
- A family history of familial adenomatous polyposis;
- Hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
- Chronic inflammatory bowel disease;
- A background, ethnicity or lifestyle that the physician believes puts the covered person at elevated risk for colorectal; or
- When prescribed by a physician

Colorectal cancer screening and laboratory testing includes:

- Screening with annual fecal occult blood tests (3 specimens);
- Flexible sigmoidoscopy every 5 years;
- Colonoscopy every 10 years;
- Double contrast barium enema every 5 years; or
- Any combination of the most reliable, medically recognized screening tests available as may be determined by the physician

14. Ancillary expenses (durable medical equipment)

We will cover the reasonable cost of rental (or purchase) of durable medical and surgical equipment when it is prescribed by a physician or specialist physician who documents whether the item is medically necessary including:

- Diagnosis and condition
- Intended use
- Rationale for use
- Expected duration of use
- Description of equipment
- Necessary for the treatment of a disease or injury or to improve body function lost as the result of a disease, injury or abnormality

Covered equipment replaces body function lost or impaired due to a disease, injury or abnormality, or must be medically necessary to enable the insured person to perform essential activities of daily living within and outside the home, related to the insured person's health and hygiene (with minimal or no assistance from others).

Equipment to enable someone to drive a vehicle or be transported in a vehicle, or equipment solely for the convenience of the insured person's caretaker is excluded from coverage.

Limits of Coverage

1. Deductibles:

The Schedule of Benefits will show the amount of coinsurance and deductible the enrolled person must pay before receiving any benefits under this policy. Any coinsurance will not apply toward meeting the deductible.

- a) Preferred care deductible (includes treatment outside of the USA): All costs for eligible treatment received outside of the USA and any eligible treatment received by a preferred care provider within the USA will apply toward the deductible. The enrolled person will be required to meet the costs of this treatment up to the preferred care deductible. Once the cost of the enrolled person's treatment exceeds the preferred care deductible, the policy will begin paying benefits for eligible treatment outside of the USA and eligible treatment by a preferred care provider within the USA.
- b) Non-preferred care deductible: Only costs for eligible treatment in the USA received by a nonpreferred care provider will apply toward the non-preferred care deductible. The enrolled person will be required to meet the costs of this treatment up to the nonpreferred care deductible. Once the cost of enrolled person's treatment exceeds the non-preferred care deductible, the policy will begin paying benefits for eligible treatment by non-preferred care providers within the USA. Each deductible stands separately and will be accrued separately. Eligible treatment requiring precertification that is not precertified will count toward a deductible only after application of the reduced reimbursement percentage.

2. Coinsurance limits:

Under certain circumstances, the enrolled person is required to pay a percentage of the total value of any claims for each medical condition for each period of coverage. This is called coinsurance and the percentage is listed in your Schedule of Benefits. The maximum amount each enrolled person must pay as coinsurance per period of coverage is called the coinsurance limit and is also listed in your Schedule of Benefits. Each enrolled person has a separate coinsurance limit for precertified treatment by preferred care providers and nonpreferred care providers. After this maximum, for which you are liable, is reached, the policy will pay benefits at 100 percent. Deductible payments do not contribute to these limits. Eligible treatment requiring precertification that is not precertified will not be subject to the coinsurance limit.

3. Application of limits:

We will apply any overall benefit limits (e.g., per visit, number of days, monetary limit, etc.) before we apply any deductibles.

4. Schedule of limits/maximums:

The full schedule of limits/maximums for all applicable coverage options are outlined in your Schedule of Benefits. Your purchased coverage option is incorporated in your Schedule of Coverage and should be referred to in order to determine how the limits will be applied to your coverage and benefits.

5. Accumulation:

Where a family with three enrolled persons or more are all involved simultaneously in an accident, a maximum two (2) individual deductibles will be applied to the total cost of the claims for the family members.

Exclusions

This policy does not cover expenses arising from:

- 1.** Any medical condition or related condition for which you have received treatment, had symptoms of or 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. Benefits for a pre-existing medical condition and/or related condition may be eligible after two (2) years of continuous coverage provided that you have not consulted a physician or specialist physician for treatment or advice, experienced further symptoms or taken medications.
- 2.** Treatment that we determine on general advice is either experimental or unproven.
- 3.** No coverage will be provided under the policy where treatment or advice of any medical condition whatsoever, whether related or not, was as a result of autotherapy (self administered) or where such treatment or advice had been given by a relative, including, but not limited to, spouse, partner, parent, grandparent, child or guardian.
- 4.** Birth injuries, congenital anomalies, genetic deformities or diseases or hereditary medical conditions established to have been present, whether symptoms have presented themselves or not, prior to your date of entry.
- 5.** Preventive medicines (except vaccinations as covered in benefit 12), normal eye tests, normal hearing tests, non-medical/natural degenerative eye defects, including, but not limited to, myopia, presbyopia and astigmatism or any corrective surgery for non-medical/natural degenerative vision or hearing defects.
- 6.** Convalescence unless it forms an integral part of treatment received under the control or supervision of a specialist physician and is undertaken in a recognized convalescent facility or as home health care.
- 7.** Treatment received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a medical facility or nursing home attached to such establishments or a medical facility where the medical facility has effectively become the insured person's home or permanent abode or where admission is arranged wholly or partly for domestic or social reasons.
- 8.** 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.
- 9.** Alternative medicines, including, but not limited to, osteopathy, chiropractics, acupuncture, homeopathy, podiatry and optometry.
- 10.** 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.
- 11.** Any second or subsequent medical opinions from a physician or specialist physician for the same medical condition unless it has been authorized by us in writing.
- 12.** Routine or restorative dental treatment, whether or not performed by a medical practitioner or dental practitioner or a specialist or an oral and maxillofacial surgeon, except as specified in benefit 5 of the policy.
- 13.** Any costs relating to pregnancy and childbirth including pre-natal, delivery and post-natal costs, terminations on non medical grounds, antenatal classes or midwifery costs.
- 14.** Any complications of pregnancy including any emergency treatment requiring a recognized obstetric procedure.
- 15.** Treatment directly or indirectly arising from or required in connection with male and female birth control, infertility, contraception, sterilization (or its reversal) and any form of assisted reproduction or any complication or pregnancy arising as a result of assisted pregnancy or fertility treatment.
- 16.** Treatment of impotence or any related condition or consequence thereof.
- 17.** Treatment directly or indirectly associated with a sex change and consequence thereof.
- 18.** Venereal disease or any other sexually transmitted diseases or any related condition.
- 19.** Corrective surgery for sight defects not incurred as a result of an accident.
- 20.** Orthodontic treatment, gingivitis and periodontitis or any related condition.
- 21.** Costs in respect of any mental disorders, whether or not requiring treatment by a psychiatric physician, psychotherapist, psychologist, family therapist or bereavement counselor.
- 22.** Treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy and developmental, social or behavioral problems in children.
- 23.** Treatment for alcoholism, drug or substance abuse or any addictive condition of any kind.

- 24.** Suicide or attempted suicide, bodily injury or illness, which is willfully self-inflicted or due to negligent or reckless behavior.
- 25.** Any injury sustained directly or indirectly as a result of the insured person acting illegally or committing or helping to commit a criminal offense.
- 26.** 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.
- 27.** Costs and expenses incurred where an insured person has traveled against general advice.
- 28.** The fees of a religious practitioner in respect of benefit 9 of the policy.
- 29.** Treatment and expenses directly or indirectly arising from or required as a consequence of: 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, unless the insured person sustains bodily injury as an innocent bystander.
- 30.** Treatment directly or indirectly arising from or required as a result of chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel, asbestosis or any related condition.
- 31.** Treatment received in connection with insomnia, sleep disorders, sleep apnea, fatigue, jet lag or work related stress or any related condition.
- 32.** 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.
- 33.** Home visits by a physician, specialist physician or qualified nurse unless specifically agreed by us in writing prior to consultation.
- 34.** Any treatment not prescribed, recommended or approved by your attending physician or specialist physician.
- 35.** Costs for treatment that you are not legally obliged to pay.
- 36.** Costs, as determined by us, to be for custodial care.
- 37.** Treatment for menopause, whether or not due to a hysterectomy or by early onset.

General conditions

Additional provisions

The following additional provisions apply to your coverage:

- This policy applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan where you hold more than one insurance policy.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the Schedule of Benefits and policy schedule. If you have any questions about the terms of the plan or about the proper payment of benefits, please contact us.

Assignments

Coverage may be assigned only with our written consent. Assignment of benefits can be completed with an out-of-network provider; however, an out-of-network provider is not required to accept our assignment.

Misstatements

If any fact as to you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount. Our failure to implement or insist upon compliance with any provision of this policy at any given time or times, 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. This applies whether or not the circumstances are the same.

Family/dependent coverage

You and all insured persons are required to be covered under the same policy with identical benefits. Where we find that this is not the case, you will be asked to comply with this request at your next renewal date. Failure to comply with this condition will result in the termination of your policy.

Acceptance clause

We are entitled to refuse to accept an application from any person without giving a reason. We maintain the right to ask you to provide proof of age and/or state of health of any person included in your application. We reserve the right to apply additional endorsements, exclusions or premium increases to reflect any circumstances you advise in your application form or declare to us as a material fact.

Eligibility

The policy is designed for expatriates. Local nationals can only be considered subject to our approval. New applicants will be eligible for coverage until the age of 65. Individuals over the age of 65 are not eligible for coverage unless the insured person's date of entry was prior to their 65th birthday. Eligibility will not extend in any event to any applicants with a country of residence, at the time of application for enrollment or any subsequent renewal date, of the USA or Bermuda, and all coverage shall terminate if you reside or come to reside for 90 consecutive days during any period of coverage in either Bermuda or the USA.

Change of risk

You must inform us as soon as reasonably possible of any material changes relating to any insured person which effects information given in connection with your application for enrollment. We reserve the right to alter the terms of this policy or cancel coverage for an insured person following a change of risk.

Policy duration and premiums

- The coverage provided is for one year and is renewable for successive one year periods, subject to the terms in force at the time of each renewal date and to payment of the premium.
- The premium payable may be changed by us from time to time. If you move into a higher age band, the premium will increase at the next renewal date. However, coverage will not be subject to any alteration in premium rates generally introduced until the next renewal date.
- All premiums are payable in advance of any coverage under this policy being provided.
- The policy is an annual contract (12 months) and you are responsible for the whole year's premium even if we have agreed that you may pay by installments.

Break in coverage

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

Children

New born children will be accepted for coverage from birth. Acceptance of new born babies is subject to receipt of an application form 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 you, or 25 years old if in full-time education, at the date of entry or at any annual renewal date, will be accepted for coverage. Children

under the age of 18 years will be accepted for coverage as the primary insured person providing the application is signed by a legal parent or guardian. The premium applicable will be the 18 – 21 age band rate.

Cancellation

In the event of any non-payment of premium, we shall be entitled to cancel the coverage for all insured persons. Cancellation will be automatic. We may at our sole discretion reinstate the coverage if the premium is subsequently paid.

While we shall not cancel this policy because of eligible claims made by any insured person, we may at any time terminate an insured person's coverage if he/she has at any time:

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

Applicable law

The law applicable to the policy, the policy schedule or to any and all causes of action arising out of, in connection with, or relating to the policy or to the policy schedule shall be the substantive laws of Bermuda, without regard or application of the conflict of laws rules of that jurisdiction.

Arbitration

Any and all disputes, controversies, and claims arising out of or in connection with the policy, the policy schedule, the application or solicitation process for either, or any service provided in connection with the subject matter of this document, shall be resolved exclusively by resort to private and confidential arbitration. Included within the scope of this agreement to arbitrate shall be any and all disputes, controversies and claims involving us, you, any insured person or anyone acting on behalf of any of them. The location of the arbitration shall be Hamilton, Bermuda at the municipal address selected by a majority of the arbitral panel (which shall consist of three arbitrators; one selected by each party and the third by the two arbitrators so selected). The arbitrators shall each have at least five years experience in the field of life and/or health insurance, and may not have (or have had for the past five years) any affiliation with either of the parties.

The decision of a majority of the arbitrators shall be binding and final and not be subject to appeal. The cost of the arbitration proceedings shall be borne as assigned by the arbitrators. To the

extent permitted by the law of Bermuda the arbitration shall be conducted in accordance with the UNCITRAL RULES for Arbitral Procedure. In all other aspects, the law of Bermuda shall govern the arbitration. In the event of an impasse regarding the selection or appointment of an arbitrator, the International Court of Arbitration of the International Chamber of Commerce shall be the appointing authority, as permitted under the UNCITRAL Rules.

Liability

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

Premium refunds

After the first 30 days of coverage from your date of entry (cooling off period), or 15 days from any subsequent renewal date, you will not be entitled to any refund of premium, either in full or in part, for whatever reason.

Transfer

If there is more than one insured person over the age of 18 and you die, the oldest insured person over the age of 18 shall upon the date of your death become responsible for paying the premium and the receipt and giving of notices.

Recovery of overpayments

If a benefit payment is made by us, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, we have the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that insured person or another person in his or her family. Such right does not affect any other right of recovery we may have with respect to such overpayment.

Reporting of claims

A claim must be submitted to us in writing. It must give proof of the nature and extent of the loss.

All claims should be reported promptly. The deadline for filing a claim is 180 days after the date of the loss. If, through no fault of your own, you are not able to meet the deadline for filing the claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Legal action

No legal action can be brought to recover payment under any benefit after three years from the deadline for insured members to file claims.

Physical examinations

We will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by us when necessary for your care or treatment, the operation of the plan and administration of this policy, or other activities, as permitted by applicable law. You can obtain a copy of our Notice of Information Practices by calling the International Member Service Center.

Subrogation

The policy shall be subrogated to all rights of recovery that you have against any other party with respect to any payment made by that party to you due to any injury, illness or medical condition you sustain to the full extent of the benefits provided or to be provided by the policy. If you receive any payment from any other party or from any other insurance coverage as a result of an injury, illness or medical condition, we have the right to recover from, and be reimbursed by you, 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 you receive.

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

You are required to fully cooperate with us in our efforts to recover any payments made under the policy including any legal proceedings which we may conduct and proceed on your behalf at our sole discretion. You are required to notify us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or medical condition sustained by you, the insured person. Other than with our written consent, you have no entitlement to admit liability for

any eventuality or give promise of any undertaking which is binding upon you, any eligible person or any other person named in the policy. 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.

Claims procedures

International Member Service Center:

All enrolled persons have access to the International Member Service Center, which is available 24 hours a day, 365 days a year, and is staffed by multilingual operators who can process claims in many different languages and can answer your questions about claims, benefits and coverage levels, and providers accepting direct-settlement. The International Member Service Center also gives you direct access to the International Health Advisory Team, who can arrange for hospital admissions, ambulance transfers and air evacuation where necessary.

To obtain assistance from the International Member Service Center, use the contact details on your Aetna membership ID card.

You will need to provide:

- your name
- policy number
- telephone and/or fax number
- location and medical condition

In any given situation, if you are unsure what to do, contact the International Member Service Center.

Claims paid in a local currency will be converted at the rate of exchange quoted on www.oanda.com, based on the date of treatment.

To safeguard you against the possibility of being faced with expenses that are not covered under your policy, we have developed the following procedures:

Planned Inpatient and Daypatient Treatment

In the event of a planned admission on an inpatient or daypatient basis to a medical facility, the following steps are to be taken. Payment of all expenses incurred by the enrolled person will only be reimbursed at 50% of the costs incurred unless you follow these procedures.

- Contact the International Member Service Center (toll-free or collect) at least five business days prior to admission, giving full details of the condition, proposed treatment (including dates and name of procedure, if known), the name of the specialist physician and details of the medical facility. (The telephone number is provided on your membership card.)
- The International Member Service Center will advise you if they have sufficient information to confirm the enrolled person's coverage. If not, they will advise you what further information is required.

- The International Member Service Center will verbally confirm the enrolled person's coverage and will dispatch written confirmation to you.
- The International Member Service Center will attempt at all times to make arrangements with the medical facility for all eligible bills to be settled directly. Where this has been arranged, you should send the original claim form and the unpaid invoices (if given to you by the medical facility) to Aetna.

Emergency Admissions:

In the event of emergency admissions, you should contact the International Member Service Center within 24 hours of admission and follow the steps described earlier for inpatient treatment. Failure to contact the International Member Service Center within 24 hours of admission will result in treatment or any evacuation cost only being reimbursed at 50% of the costs incurred within the terms of the certificate. Please do not delay in obtaining emergency treatment.

Outpatient Treatment:

If you receive medical treatment as an outpatient, treatment may be paid for in full by you at the time of the appointment and re-claimed from us. In such instances, please ensure that a claim form is completed by you and the physician or specialist physician. Please remit this to Aetna with all substantiating proof of the enrolled person's claim, including, but not limited to, the original invoice and proof of payment, prescription and written diagnosis from the physician.

For high cost outpatient procedures, direct-settlement may be available. You must contact Aetna to initiate a direct-settlement at least five business days prior to planned treatment. If you choose to seek treatment at a direct-settlement provider without notifying Aetna in advance, the provider may expect payment in full at the time of service.

When seeking outpatient treatment it is important that you present your Aetna ID card to the medical center/provider before treatment begins.

While we work as closely as possible with our international providers to ensure that direct-settlement remains available for low cost outpatient treatments, most providers ask for a credit card swipe or cash deposit to cover deductibles, copays/coinsurance payments and/or non-covered items.

Guarantee of Payment (GOP)/Precertifications:

We require members to obtain prior approval (precertification) from us before commencing the following treatments:

- Planned inpatient or day patient treatment (hospitalization)
- Planned surgery
- Evacuation
- Second medical opinions
- Psychiatric treatment – inpatient, day patient and outpatient
- Home health care charges
- Planned MRI and CT scans

Evacuations are supervised by your physician or specialist physician at the place of incident and by our International Member Service Center, and must be agreed by us before evacuation takes place.

The below information/documents are required in order to process a GOP/precertification in a timely manner:

- Diagnosis
- Treatment
- Date of Service
- Provider's name and contact person
- Provider's phone and fax number or e-mail
- Medical records/medical notes
- Cost estimate
- Release of Medical Information Form
- Precertification Medical Form

GOPs/precertification requests may take up to two business days to approve once we receive all of the required information. However, we will try to expedite it, when requested. Some cases may take longer to approve based on the type of request (e.g., translations of medical records, transplants, TMJ syndrome, etc.)

Once we approve the precertification request, we will e-mail a copy of the GOP letter to you or the provider.

General Claims Information:

We reserve the right to reject any claim that is not submitted within 180 days of the date treatment took place. All documents and materials (including, but not limited to, original accounts, certificates and x-rays) that we require to support a claim, an application for coverage or change in coverage shall be provided without expense to us (including if requested by us a medical report from enrolled person's physician or specialist physician and details of the enrolled person's medical history prior to any claim). In cases where medical information is required by us for consideration of a claim but it is not available to us, it is your responsibility to obtain such information from the enrolled person's current or previous physician, as appropriate. Claims may only be made for treatment actually given during a period of coverage and benefit will be available only for expenditures incurred prior to expiration or termination of such coverage.

An enrolled person must, without delay, give us written notification of any claim or right of action against any third party arising out of circumstances that gave rise to a claim under this policy and must continue to keep us fully informed in writing and take all steps we reasonably require in making a claim upon that other party. We shall be entitled to take legal action in any enrolled person's name for our own benefit and claim for indemnity or damages or otherwise which relates to any benefits and costs paid or payable under this policy. We shall have full discretion in the conduct of any such proceedings and in the settlement of any such claim.

Contact information

Customer service:

Toll-free phone: +1-866-949-6027

Direct phone: +1-813-775-0034

Fax: +1-860-262-9111

Claim submission

Web: www.aetnainternational.com

E-mail: americasservices@aetna.com

Fax: +1-860-262-9111

Mail: Aetna International
P.O. Box 30545
Tampa, FL 33630-3548

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