

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna[®]

Discover the benefits of flexible global care

International Healthcare Plan

www.aetnainternational.com



You can count on us to deliver on the goals that matter most to your business and your employees. We share your commitment to caring for your employees and it comes across in everything that we do.

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Benefits backed by strength and stability

As a part of Aetna, Inc., we share in the heritage of more than 160 years of expertise as a leading provider of health care benefits. For more than three decades, we've extended that strength and stability across the globe as one of the world's largest and most prominent providers of international health benefits. Today, we support more than 500,000 members worldwide.

WE HAVE MORE THAN 700 DEDICATED EMPLOYEES WORLDWIDE.

This includes locations in:

- Greater China (Hong Kong and Shanghai)
- Southeast Asia (Manila, Philippines; Singapore, and Jakarta, Indonesia)
- Middle East (Dubai, Abu Dhabi, Qatar, and Kuwait)
- United Kingdom (London, England; Birmingham, England)
- United States (Tampa, Florida; New Albany, Ohio; Blue Bell, Pennsylvania and Hartford, Connecticut)





Delivering on the promise of quality health care

Global support that centres on your employees

Your employees will have the local support of our on-the-ground teams along with the global strength of our worldwide network. This means they will have access to exceptional care no matter where they are.

Your employees will have access to:

- One-on-one health care support from our International Health Advisory Team (IHAT) of clinicians
- A direct settlement provider community of more than 100,000 leading hospitals and clinics
- Claims reimbursement in over 135 currencies
- Web and mobile tools that help employees play a greater, more informed role in their health
- 24x7x365 multilingual member service support

In short, we'll go above and beyond to make sure that your professionals are well cared for, wherever they are in the world.

A focus on helping your business

We leverage our deep market knowledge and in-country expertise to help you manage and minimise costs and challenges. This includes being a partner who takes responsibility for the health and well-being of your employees. We'll work with you to understand your business and the needs of your global workforce so we can provide proactive support, clear guidance and meaningful solutions that drive healthy outcomes.

Here's what you can expect from us:

- Better management of medical costs
- Dedicated, proactive account management
- Simplified compliance with built-in regulated solutions
- Flexible, portable solutions

As our customer, you'll gain the support of our global network of professionals who share your commitment to caring for your employees around the world.

Value-added wellness programmes

Wellness is a lifelong path, and the journey is different for each individual.

It begins with getting members engaged in their own well-being and supporting them wherever they are on their journey — whether they are healthy, at risk for disease or injury, managing a chronic condition or experiencing a major health event.

With this in mind, we've developed a complimentary wellness offering for members, which includes the following programmes:

Wellness Checkpoint®

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

We also offer additional tiers of Wellness Checkpoint for groups over 100 members, which can include varying levels of customisation — from tailored reporting to a fully-bespoke tool. Please consult with your Aetna representative for additional information.

Health and wellness education

Whether employees are healthy individuals looking for additional healthy lifestyle tips — or have a chronic condition and want to learn how to reach their optimal state of health — we offer an array of health and wellness education materials to aid them in their efforts.

The health library provides helpful information, including topics such as:

- Asthma
- Cancer
- Coronary artery disease
- Maternity
- Stress management



International Healthcare Plan Overview

An innovative, flexible offering

No two companies are alike. That's why we offer a range of plans and optional benefits so you can maximise your health care investment and manage costs based on your varied employee populations. You can select from one of four base plans, then choose from a menu of additional benefits and sums insured.

This means you have the flexibility to provide different plans for different groups of employees within the same policy. For example, you can set up different categories for employees working in different regions, which provide different levels of cover, such as including extended evacuation assistance for employees who travel more frequently than others.

For qualifying groups of 50 or more employees, you can benefit from the additional flexibility of a custom plan that includes additional benefits and increased limit options.

A collaborative approach

Our team is committed to working with you to identify the plan type and benefits that are best for your business and the employees you're looking to cover.

STEP 1:
***Choose a base plan
and excess level.***

STEP 2:
***Choose your
optional benefits.***

STEP 3:
***Tailor the level
of cover for your
optional benefits.***

Core**Essential****Plus****Elite****Core**

A comprehensive range of benefits, including, but not limited to:

- Inpatient and day patient treatment benefits
- Evacuation and transportation benefits
- Accident and emergency treatment outside area of cover
- Outpatient care (with a capped benefit)

Essential

Core benefits, plus:

- Chronic conditions benefit
- Outpatient psychiatric treatment
- Increased outpatient care benefit (fully covered)
- Alternative Treatment

Plus

Essential benefits, plus:

- Hospice care
- Increased hospital cash benefit
- Increased chronic conditions benefit
- Increased alternative treatment (20 sessions)
- Increased vaccinations and inoculations benefit
- Increased home nursing benefit

Elite

Plus benefits, plus:

- Compassionate emergency travel
- Increased maximum annual aggregate limit
- Increased level of cover for a number of benefits, including: hospital cash, chronic conditions, congenital anomalies, durable medical equipment, AIDS, hospice care, alternative treatment (30 sessions), evacuation and additional travel expense, mortal remains and new born care

Optional benefits either reduce costs* and/or upgrade cover.

See pages 6 – 10 for a full list of options, which include, but are not limited to:

- Extended emergency evacuation
- Infertility treatment
- Inpatient bed limit*
- Out of country transportation
- Outpatient consultation copay per visit*
- Routine or restorative dental and orthodontic options
- Routine pregnancy
- Traditional Chinese or Ayurvedic medicine
- USA elective treatment
- Vision care
- Wellness options

Many of the options can be flexed. For example, we offer a range of benefit limits within our seven routine or restorative dental and orthodontic options — with the ability to include or exclude a coinsurance.

International Healthcare Plan benefits comparison

To find out about the key features of the International Healthcare Plan, please see the following comparative benefits schedule.

This will be a 12 month policy starting from the date of entry or any subsequent renewal date, as applicable.

It is the responsibility of the policyholder to continually review your policy in order to ensure that the plan selected continues to meet the needs and requirements of your employees.

This policy summary does not contain the full terms of the policy; these can be found in the benefits schedule, group contract, certificate of insurance and member handbook.

It is the responsibility of the policyholder to continually review your policy in order to ensure that the plan selected continues to meet the needs and requirements of your employees.

	Core	Essential	Plus	Elite
Maximum annual aggregate limit	A maximum of \$1,600,000 per member per period of cover	A maximum of \$2,500,000 per member per period of cover		A maximum of \$5,000,000 per member per period of cover
Inpatient, day patient, emergency care and diagnostics				
Inpatient care, reconstructive surgery and rehabilitation	Covered in full i) Accommodation is subject to any selected inpatient bed limit ii) Rehabilitation is covered in full up to 120 days per medical condition			
Accident and emergency treatment outside area of cover	Covered in full for inpatient treatment Outpatient treatment is limited to \$500 per medical condition and subject to an excess of \$80 per medical condition			
CT PET and MRI scans	Covered in full			
Organ transplant	Covered in full			
Inpatient psychiatric treatment	Covered in full (up to 30 days) per period of cover			
Accidental damage to teeth	Covered in full			
Hospital cash	Up to \$125 per night for a maximum of 20 nights per medical condition	Up to \$175 per night for a maximum of 20 nights per medical condition	Up to \$175 per night for a maximum of 20 nights per medical condition	Up to \$250 per night for a maximum of 20 nights per medical condition
Parental accommodation	Covered in full			
Disease and chronic condition management				
Oncology	Covered in full			
Chronic conditions	No cover	Up to \$5,000 per insured person per period of cover	Up to \$15,000 per insured person per period of cover	Up to \$30,000 per insured person per period of cover
Congenital anomalies	Up to \$100,000 per medical condition			Up to \$250,000 per medical condition
Durable medical equipment, prosthetic and orthotic supplies (DMEPOS)	Up to \$1,000 per medical condition			Up to \$10,000 per period of cover
AIDS	Up to \$10,000 per insured person per period of cover			Up to \$20,000 per insured person per period of cover
Hospice care	No cover		Up to \$25,000 per lifetime	Up to \$50,000 per lifetime
Hormone replacement therapy	Covered in full up to 18 months per lifetime			

	Core	Essential	Plus	Elite
Outpatient and alternative treatments				
Outpatient care	Up to \$1,700 per medical condition prior to hospitalisation and up to 60 days immediately following hospitalisation. Alternative treatment up to 10 sessions in aggregate per medical condition, and subject to the benefit limit above.		Covered in full	
Outpatient surgery			Covered in full	
Outpatient psychiatric treatment	No cover		Up to \$5,000 per period of cover	
Alternative treatment	See outpatient care	Covered in full up to 10 sessions in aggregate per medical condition	Covered in full up to 20 sessions in aggregate per medical condition	Covered in full up to 30 sessions in aggregate per medical condition
Vaccinations and inoculations		Up to \$100 per period of cover		Up to \$500 per period of cover
Home nursing		Covered in full up to 30 days per medical condition		Covered in full up to 28 weeks per medical condition
Evacuation and transportation				
Emergency transportation			Covered in full	
Evacuation and additional travel expense i) Travel ii) Non-hospital accommodation		i) Covered in full ii) Up to \$150 per person per day and \$5,000 per person per evacuation		Up to \$250 per person per day and \$10,000 per person per evacuation
Compassionate emergency travel		No cover		Offered as standard up to \$3,000 per period of cover
Mortal remains		Up to \$8,500 per insured person		Up to \$15,000 per insured person
Mother and child				
Complications of pregnancy			Covered in full	
New born care		Up to \$100,000 per insured person per period of cover and to a maximum of 90 days hospital stay		Up to \$250,000 per insured person per period of cover and to a maximum of 180 days hospital stay
New born accommodation			Covered in full	

	Core	Essential	Plus	Elite
Options to reduce costs				
China private room restriction			Covered in full	
Hong Kong semi-private room restriction			Covered in full	
Outpatient consultation copay per visit This benefit is available where nil excess has been selected.	No cover		\$15 copay per visit or deductible OR \$20 copay per visit or deductible OR \$30 copay per visit or deductible	
Inpatient bed limit			6 standard options ranging from: Inpatient bed limit \$75 per day, to inpatient bed limit \$500 per day	
Options to upgrade cover				
Alternative treatment without medical referral	No cover		Up to \$1,000 per insured person per period of cover OR Up to \$2,000 per insured person per period of cover	
Chronic conditions	No cover	No additional options available – see above standard chronic conditions benefit		Covered in full
Compassionate emergency travel		No cover		See above listed compassionate emergency travel benefit — offered as standard up to \$3,000 per period of cover
Complications of pregnancy – no wait period			Covered in full	
Congenital anomalies – Including pre-existing congenital anomalies			Covered in full OR Up to \$100,000 per medical condition OR Up to \$250,000 per medical condition	
Dental 1 – routine dental treatment	No cover		14 standard options ranging from: Up to \$250 per period of cover (with or without 25% coinsurance), to up to \$2,500 per period of cover (with or without 25% coinsurance)	
Dental 2 – major restorative treatment	No cover		12 standard options ranging from: Up to \$500 per period of cover (with or without 25% coinsurance), to up to \$2,500 per period of cover (with or without 25% coinsurance)	
Dental 3 – orthodontic dental treatment	No cover		6 standard options ranging from: Up to \$500 per period of cover (with or without 50% coinsurance), to up to \$1,500 per period of cover (with or without 50% coinsurance)	
Dental 4 – dental implants	No cover (available to custom plans only)			
Dental 5 – combined routine and restorative dental	No cover		Up to \$1,500 per period of cover (with or without 25% coinsurance)	
Dental 6 – combined routine and restorative dental with orthodontics	No cover		Up to \$2,500 per period of cover (with or without 25% coinsurance)	
Dental 7 – combined routine and restorative dental with orthodontics and dental implants	No cover		Up to \$3,000 per period of cover (with or without 25% coinsurance)	
Outpatient direct settlement network – nil excess This benefit is available where a nil, \$50 OR \$100 policy excess has been selected.	No cover		Outpatient consultations are available on a nil excess basis where treatment is received in network. The policy excess applies where outpatient consultations take place outside the direct settlement network.	

	Core	Essential	Plus	Elite
Extended evacuation (to the country of choice)	Covered in full			
Out of country transportation for medically necessary non-emergency treatment as an inpatient or day patient i) Travel ii) Non-hospital accommodation	i) Covered in full ii) Up to \$150 per person per day and \$5,000 per person per evacuation <i>OR</i> ii) Up to \$250 per person per day and \$10,000 per person per evacuation			
Hearing benefit	No cover (available to custom plans only)			
Infertility treatment (minimum of 10 employees required)	No cover		Up to \$25,000 per member per lifetime	
Routine pregnancy	No cover	8 standard options ranging from: Up to \$5,000 per pregnancy (with or without 20% coinsurance), to covered in full per pregnancy (with or without 20% coinsurance)		
Traditional Chinese or Ayurvedic medicine	No cover	5 standard options ranging from: \$30 per session to a maximum of 10 sessions, to up to \$750 per period of cover <i>Two additional options are available for custom groups.</i>		
USA elective treatment i) Inpatient or day patient treatment received inside the direct settlement network ii) Inpatient or day patient treatment received outside the direct settlement network iii) Outpatient treatment The International Healthcare Plan (IHP) does not comply with the Patient Protection and Affordable Care Act (U.S. healthcare reform), and cannot be used to satisfy any requirements for health insurance cover mandated therein.	No cover	i) Covered in full ii) Up to \$1,000,000 per member per period of cover and subject to 50% coinsurance iii) Covered in full		
Vision care	No cover	One eye exam and a maximum benefit of up to \$250 per period of cover <i>OR</i> One eye exam and a maximum benefit of \$500 per period of cover <i>OR</i> One eye exam and a maximum benefit of \$750 per period of cover		
Wellness option 1 Routine medical checkups and well-baby checks	Up to \$250 per insured person per period of cover			
Wellness option 2 Bilateral mammogram/breast examination and routine gynaecological tests including PAP tests Testicular/prostate examination/PSA/DRE tests Routine medical checkups Well-baby checks	Up to \$500 per insured person per period of cover <i>OR</i> Up to \$750 per insured person per period of cover <i>OR</i> Up to \$1,000 per insured person per period of cover <i>OR</i> Up to \$1,500 per insured person per period of cover			
Wellness option 3 Preventive screening for members who are deemed at high risk	No cover	Up to \$1,000 per insured person per period of cover <i>OR</i> Up to \$1,500 per insured person per period of cover		

	Core	Essential	Plus	Elite
Excess				
Policy excess level options — The excess level selected for this policy will be applicable to each new medical condition.				
\$0	Standard			Optional
\$50	N/A			Optional
\$100	N/A			Standard
\$250	N/A			Optional
\$500	N/A	Optional		N/A
\$1,000		Optional		N/A
\$2,000	N/A	Optional		N/A
\$5,000		Optional		N/A



Important information

Section 25(5) of the Insurance Act (Cap 142) requires that you disclose fully and faithfully in your application for cover, any information or facts which you know or ought to know, otherwise you may receive nothing from the plan.

Medical underwriting

For groups of less than 20 employees, we require a completed member application form for each employee.

Our standard approach to medical underwriting is moratorium; however, plan sponsors may elect to purchase enhanced underwriting terms for the group.

Moratorium underwriting

Our standard approach to medical underwriting.

At the member level, cover is not provided for any medical condition in existence on the date that individual is accepted into the group (date of entry) until it has been treated such that the individual is symptom and advice-free for two consecutive years following the date of entry with regard to that medical condition. This policy does not cover the treatment of pre-existing chronic conditions.

Full medical underwriting

Plan sponsors may also elect to have members fully underwritten.

Should we accept cover, we may apply additional terms and exclusions, which will be shown on the member's certificate of insurance.

Continuous transfer terms

For members wishing to transfer from other policies. This feature may incur additional premium.

The acceptance by us of the member's original date of entry as shown by the member's current insurer will be applied to the member's policy with us. We will maintain the member's existing underwriting or special acceptance terms, as offered by the member's existing insurer, such as any moratoria or specific exclusions, and the member's 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.

Medical history disregarded

Available to compulsory group schemes of 10 employees or more.

Cover is extended to include treatment for any medical condition or related condition where symptoms have existed or advice has been sought prior to the member's date of entry.

All members must be enrolled within 30 days of eligibility. Any employee or dependant not covered within 30 days of eligibility will be subject to individual medical underwriting.

When MHD is selected for your policy, any waiting periods are removed from benefits that are stated to contain them.

Cover is not extended to include treatment for congenital conditions unless the member has been enrolled within the first year following birth, or unless the optional benefit for

congenital anomalies — including pre-existing congenital anomalies' has been purchased.

Plan currency

The US Dollar (\$) currency is available to policyholders in Philippines.

Payment frequency

Bank transfers or cheques are available on an annual, semi-annual or quarterly basis. These are accepted in the US Dollar.

Communicating with your employees

To assist you in communicating your benefits to your employees and their dependants, we provide the following options:

- Electronic member packs and mailed membership cards
- Printed copies of member packs and membership cards

Membership adjustments

There are three options for plan sponsors to adjust membership when members leave or join the plan:

- **Pay as you go** — Adjustments are credited or debited as adjustments are made.
- **Periodic adjustments** — We will adjust your instalment plan to incorporate membership adjustments.
- **End of year adjustments** — We will reconcile your account at year end.

Policyholder's right of termination

This policy may be terminated by the policyholder, as to all or any class of its members, by notifying us in writing within 14 business days from the date the policyholder receive the policy document and, provided no claims have been made, we will arrange a full refund of any premiums paid. The policy document is deemed to have been received by the policyholder within 3 days after we have dispatched it. Otherwise, this policy, or any cover included, may only be terminated by the policyholder, as to all or any class of its members, with effect from the renewal date. We must be given written notice of intent to non-renew within 15 days of your renewal date. If the policy is terminated by the policyholder at any other time, as to all or any class of its members, we must be given written notice not less than 15 days. In the event of such termination, we shall return the pro-rated premium to the policyholder.

Policy Owners' Protection Scheme — Disclosure Statement

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the GIA/LIA or SDIC websites www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg.

Common questions and answers

Q. Are all employees, at home or abroad, eligible for cover?

A. New applicants will be eligible for cover up until the age of 65. The plan will cover employees who live or work outside of the country that issued their passport. Any employee or dependant (subject to the agreement of the plan sponsor) not enrolled within 30 days of eligibility will be subject to individual underwriting.

Q. Are family members eligible for cover as well?

A. 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 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.

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.

Q. Is a medical examination required to enrol in the plan?

A. No. In the rare instance that we require additional information for fair and accurate underwriting purposes, we will ask the applicant to submit a medical report from his/her doctor.

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

A. If you select a moratorium underwriting basis, cover for all pre-existing medical conditions are excluded during the first two years of membership. Future costs will be covered providing members do not have any symptoms, treatment or advice for that condition during this two year period.

You may also apply for Continuous Transfer Terms (CTT). For groups of 10 or more employees, you may purchase Medical History Disregarded cover.

Q. Does the plan include cover for elective treatment in the U.S.?

A. Cover for elective treatment in the U.S. is only available if the USA Elective Treatment option is selected. This can be purchased with the Essential, Plus and Elite plans.

Where the plan sponsor has not elected to provide USA Elective Treatment, members are covered for accidents and emergencies only. Travelling expenses will be covered under the Evacuation benefit in the event of an emergency, if the visiting location does not offer the appropriate treatment or care needed.

Q. How is the policy excess applied?

A. Members are responsible for paying the policy excess.

Q. How do members know if inpatient treatment is covered?

A. All inpatient treatment is required to be pre-authorized prior to a planned admission into a hospital. Members should contact the Aetna International Member Service Centre to determine whether treatment is covered under the policy.*

Q. How can members submit a claim?

A. Upon inception, each member will receive a membership card. This provides them with the contact information for the Aetna International Member Service Centre and information they need to register for the Aetna International secure member website. Members can use either resource to submit a claim.

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.

*Settlement can be made directly to the hospital. Full details of the claims procedure are available in the member handbook.

Appendix: Benefits schedule detail

Your policy may include some of the following benefits. To confirm the benefits included in your policy, please refer to your benefits schedule.

All benefits are subject to the maximum annual aggregate limit and the sums insured indicated in your benefits schedule, the applicable medical underwriting, the member's certificate of insurance and our general conditions and exclusions.

All costs incurred must be medically necessary and subject to reasonable and customary charges, based on the average treatment costs applicable to the region in which the treatment was received, as determined by us. Inpatient accommodation costs are for a standard private room unless the plan sponsor has opted to apply an alternative bed limit.

Inpatient care, reconstructive surgery and rehabilitation

Charges incurred for the treatment of a medical condition, including stabilisation of an acute exacerbation of a chronic condition, when treatment is received as an inpatient or day patient including:

- i) Accommodation and associated charges.
- ii) Admittance to the intensive care unit.
- iii) Nursing by a qualified nurse.
- iv) Surgical procedure fees and operating theatre fees.
- v) Medical practitioner fees including surgeon, consultations, specialist and anaesthetist fees.
- vi) Diagnostic procedures including but not limited to pathology tests, Ultrasound scans and X-rays.
- vii) Drugs, dressings, medicines and appliances prescribed by a medical practitioner or specialist, including Traditional Chinese Medicine.
- viii) Reconstructive surgery (including outpatient treatment) to restore natural function or appearance required as a result of an accident or illness occurring during the period of cover and where treatment takes place within 12 months of the insured event occurring.
- ix) Rehabilitation (including outpatient treatment) in a recognised rehabilitation unit of a hospital subsequent to inpatient treatment lasting 3 days or more. The rehabilitation must take place within 14 days of discharge from the inpatient admission and must be recommended and under the direct control of a Medical Practitioner. Treatment includes the use of special treatment rooms, physical and/or speech therapy fees, and other services usually given by a rehabilitation unit.

Accident & emergency treatment outside area of cover:

Benefit is payable for medical expenses which arise as a result of an emergency, which requires the member to seek treatment in the accident and emergency unit of a hospital whilst temporarily travelling inside the USA and where the medical condition did not exist prior to travel and the member was treatment-, symptom- and advice- free.

This benefit extends to include outpatient treatment arising as a result of an accident or emergency, whilst the member is temporarily travelling in the USA and where the medical condition did not exist prior to travel and the member was treatment-, symptom- and advice- free. For outpatient treatment, a benefit excess applies.

In the event of accident and emergency treatment being required inside the USA, the member should contact us either before or as soon as possible after admission to the accident and emergency unit of the hospital.

Complications of pregnancy and/or childbirth are not covered under this benefit.

CT PET and MRI scans: Scans received as an inpatient, day patient or outpatient.

This must be pre-authorised by us.

Organ transplant: The organ transplants covered under this policy are as follows: heart, heart/lung, lung, kidney, kidney/pancreas, liver, allogenic bone marrow and autologous bone marrow.

Inpatient psychiatric treatment: Treatment received in a registered psychiatric unit of a hospital. All benefits are conditional on pre-authorisation from us and all treatment being administered under the control of a registered psychiatrist. Without our written confirmation prior to such treatment, we will not be liable to pay any benefit. However, the initial consultation with the medical practitioner (not a psychiatric specialist) that results in a psychiatric referral is covered without the requirement for pre-authorisation.

Accidental damage to teeth: Treatment received in an accident and emergency ward of a hospital or dental clinic, within 10 days of incurring accidental damage to sound, natural teeth, except when the accidental damage has been caused through eating. Follow-up treatment is limited to one visit within 30 days following your initial treatment and must be pre-authorised by us.

Hospital cash: Where the member receives treatment for an eligible medical condition as an inpatient and no costs are incurred for accommodation and treatment, we will pay a cash benefit. To claim this benefit, the member should ask the hospital to sign and stamp their claim form.

This benefit is not applicable to admissions into the accident and emergency facility of the hospital.

For this benefit, the policy excess does not apply.

Parental accommodation: Hospital accommodation costs of a parent or legal guardian staying with a member who is under 18 years of age and is admitted to hospital as an inpatient.

Disease and chronic condition management

Oncology: Covers all medically necessary treatment received for, or related to, the diagnosis of cancer when received as an inpatient, day patient or outpatient including palliative treatment.

Chronic conditions: Routine checkups, drugs and dressings prescribed for management of the condition, hospital accommodation nursing, renal dialysis, surgery and palliative treatment of chronic conditions (excluding cancer). Costs for the treatment of cancer are covered under the oncology benefit.

For this benefit, the policy excess does not apply.

Congenital anomalies: Treatment of congenital anomalies that manifest after the member's cover commences with us, or which manifest in a dependant child born in the year prior to cover commencing with us.

Durable medical equipment, prosthetic and orthotic supplies (DMEPOS): The following benefits are covered:

- i) Medically necessary durable medical equipment prescribed by a treating Medical Practitioner, which is necessary to deliver or facilitate the delivery of prescribed drugs and dressings. This excludes hearing aids unless the hearing benefit has been purchased.
- ii) Ancillary charges following treatment as an inpatient or day patient including the purchase or rental of crutches and costs associated with the initial purchase or rental of a wheelchair.
- iii) External prosthetics required following surgery, including braces and calipers, artificial eyes and the initial purchase and fitment of an artificial limb.
- iv) Orthotic supplies including insoles and orthotic supports.

This benefit excludes provision, modifications and fitment of furniture or adaptations to the home.

AIDS: Medical expenses that arise from, or are in any way related to, Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof.

Expenses are limited to pre- and post-diagnosis consultations, routine checkups for this condition, drugs and dressings (except experimental or those unproven), hospital accommodation and nursing fees.

For this benefit, the general exclusion for sexually transmitted diseases does not apply.

Hospice care: Treatment provided by a hospice for the care of a member upon diagnosis of 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 medical practitioner or specialist.
- iii) Physiological and dietary counselling.
- iv) Consultation or case management services by a medical practitioner or specialist.
- v) Part-time or intermittent qualified nurse services for up to eight hours in any one day for outpatient care.

Hormone replacement therapy: Medical practitioner or specialist consultations and the cost of prescribed tablets, implants or patches when treatment is for the female menopause, which has been induced artificially and/or through early onset (by early onset we mean prior to age 40).

Outpatient and alternative treatments

Outpatient care: Medical practitioner, specialist, consultant and nursing fees and outpatient charges including diagnostic and surgical procedures including pathology, X-rays, drugs and dressings and appliances prescribed by a medical practitioner or specialist. Physiotherapy on referral by a medical practitioner is restricted to 10 sessions per medical condition, after which it must be further reviewed by a specialist. A medical report will be required for outpatient physiotherapy after 10 sessions. A referral letter/report must be submitted with the first claim for such treatment.

Outpatient psychiatric treatment: For outpatient psychiatric treatment, including specialist consultations, all treatment must be pre-authorized by us and must at all times be administered under the direct control of a medical practitioner. Without our written confirmation prior to such treatment, we will not be liable to pay any benefit. However, the initial consultation with a medical practitioner (not a psychiatric specialist), which results in a psychiatric referral, is covered without the requirement for pre-authorization.

Outpatient surgery: This benefit extends to cover the cost of endoscopy investigations carried out under an outpatient basis. This includes gastroscopy, bronchoscopy, colonoscopy and colposcopy, but excludes laparoscopy and arthroscopy, which are covered under the inpatient care benefit.

Alternative treatment: Treatment administered by registered chiropractors, osteopaths, homeopaths, podiatrists and acupuncturists when given under the direct control of and following referral by a medical practitioner or specialist.

Vaccinations and inoculations: Vaccinations and inoculations, including those that are medically necessary for travel.

Home nursing: Nursing care given outside a hospital that is immediately received subsequent to treatment as an inpatient or day patient on the recommendation of a specialist. This must be provided by a qualified nurse and not provided for domestic reasons or convenience.

This must be pre-authorized by us.

Evacuation and transportation

Emergency transportation: Emergency transportation costs to and from hospital to receive treatment as an inpatient or day patient, by the most appropriate transport method when considered medically necessary by a medical practitioner or specialist.

This benefit does not include the cost of car hire.

Evacuation & additional travel expense: Evacuation of a member in the event of an emergency, where treatment is not readily available at the place of the incident, to the nearest appropriate medical facility as determined by us, by the most appropriate method of transportation as determined by us, for the purpose of admission to hospital as an inpatient or day patient.

Evacuation is subject to written agreement from us, prior to travel and certified instructions to us from the attending medical practitioner or specialist, including confirmation that the required treatment is unavailable at the place of incident.

This benefit excludes all maternity and childbirth costs except where these are covered under the benefit for complications of pregnancy, and any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts. Cover is provided for:

- i) Evacuation costs including the costs of one other person to travel with the member as an escort, if medically necessary.
- ii) Travel to and from medical appointments when treatment is being received as a day patient.
- iii) For an accompanying person to travel to and from the hospital to visit the member following admission as an inpatient.
- iv) Economy class airline tickets to return the member and the escort to the country of residence or to the country where evacuation occurred.
- v) Non-hospital accommodation for the member and escort for immediate pre- and post-hospital admission periods provided that the member is under the care of a specialist.

Compassionate emergency travel: Reasonable travel and accommodation expenses in respect of one member, together with any minors (under the age of 16) necessarily having to travel to and the return journey from the normal country of nationality or country of residence of a near relative who has unexpectedly been placed on the critical list following an accident.

Mortal remains: In the event of death from an eligible medical condition: Transportation of the body of a member or his/her ashes to the country of nationality or country of residence or burial or cremation costs at the place of death in accordance with reasonable and customary practice.

Necessary burial or cremation fees including:

- The cost of reopening a grave and burial costs, or
- The cost of opening a new grave and burial costs, including any exclusive right of burial fee, or
- In the case of cremation
 1. The cremation fee
 2. The cost of any doctor's certificates
 3. The cost of removing a pacemaker or other medical device which must be removed before the cremation

But not including costs related to other funeral expenses, such as:

- Funeral director's fees
- Flowers
- The cost of any documents needed for the release of the money, savings and property of the deceased
- The necessary cost of a return journey for you to either
 1. Arrange the funeral, or
 2. Attend the funeral

Mother and child benefits

Complications of pregnancy: Treatment of a defined medical condition arising during the antenatal stages of pregnancy or during childbirth. The conditions covered are ectopic pregnancy, gestational diabetes, hydatidiform mole, miscarriage (actual or threatened), pre-eclampsia, failure to progress in labour or stillbirth. Post-partum hemorrhage and retained placental membrane that occur during childbirth are also covered by this benefit. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births are excluded from this benefit. Post natal checkups needed as a result of one the above complications of pregnancy are covered for a period of 6 weeks. This benefit is payable after the first 12 months from the commencement date or date of entry, whichever is the later.

New born care: Inpatient treatment of an acute medical condition being suffered by a new born baby that manifests itself within 30 days following birth. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births are excluded from this benefit. In circumstances where a congenital anomaly manifests itself in a new born baby, cover will be excluded under this benefit and payable under the benefit for congenital anomalies.

The new born baby must be added to the policy to avail of this benefit. Following the 30 day new born benefit period, excepting any medical conditions occurring or manifesting themselves during the 30 day period immediately following birth, the member's dependant will be eligible for cover subject to written notification within 30 days of birth and all premiums being paid in full within 30 days of the due date. A declaration of health is required with respect to all dependants who are born following infertility treatment (assisted conception).

New born accommodation: Hospital accommodation costs relating to a **new born** baby (up to 16 weeks old) to accompany its mother (being a member) whilst she is receiving treatment as an inpatient in a hospital, following discharge from the original delivery.

Additional options to reduce costs

Outpatient consultation copay per visit: This benefit is available where nil excess has been selected. Outpatient consultations taking place in the network are subject to a copay per visit. Where consultations take place out of network, or a claim is submitted by the member for reimbursement, a deductible is payable for each visit.

Outpatient consultations for the following benefits can be covered subject to their inclusion in your plan, and up to the value of cover selected.

- i) Complications of pregnancy
- ii) Congenital anomalies
- iii) CT and MRI scans
- iv) Hormone replacement therapy (HRT)
- v) Oncology
- vi) Outpatient care
- vii) Outpatient psychiatric treatment
- viii) Outpatient surgery

Inpatient bed limit: Inpatient bed costs are restricted to the selected inpatient limit, unless in respect of HDU and ITU admissions, which remain fully covered.

Hong Kong semi-private room restriction: This benefit is available to residents of Hong Kong only. This benefit fully refunds the cost of a semi-private room or corresponding rates when receiving treatment as an inpatient or day patient.

China private room restriction: This benefit is available to residents of mainland China only. Benefit is restricted to semi-private room and corresponding rates when receiving treatment as an inpatient or day patient outside mainland China.

Additional options to upgrade cover

Alternative treatment — Without medical referral:

Treatment administered by registered chiropractors, osteopaths, homeopaths, podiatrists and acupuncturists.

Chronic conditions: Routine checkups, drugs and dressings prescribed for management of the condition, hospital accommodation nursing, renal dialysis, surgery and palliative treatment of chronic conditions (excluding cancer). Costs for the treatment of cancer are covered under the oncology benefit.

The policy excess does not apply.

Compassionate emergency travel: Reasonable travel and accommodation expenses in respect of one member, together with any minors (under the age of 16) necessarily having to travel to and the return journey from the normal country of nationality or country of residence of a near relative who has unexpectedly been placed on the critical list following an accident.

Congenital anomalies — Including pre-existing congenital anomalies: Treatment of congenital anomalies.

Complications of pregnancy — No wait period: Treatment of a defined medical condition arising during the antenatal stages of pregnancy or during childbirth. The conditions covered are ectopic pregnancy, gestational diabetes, hydatidiform mole, miscarriage (actual or threatened), pre-eclampsia, failure to progress in labour or stillbirth. Post-partum hemorrhage and retained placental membrane that occur during childbirth are also covered by this benefit. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births are excluded from this benefit. Post natal checkups needed as a result of one the above complications of pregnancy are covered for a period of 6 weeks.

Dental 1 — Routine dental treatment: Fees of a dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment is defined as:

- Examinations
- Tooth cleaning
- Normal compound fillings
- Simple non-surgical extractions

This benefit excludes orthodontic treatment, restorative treatment and dental implants. For this benefit, the policy excess does not apply.

A 6 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

Dental 2 — Major restorative dental treatment:

This benefit covers the fees of a dental practitioner and associated costs for the treatment of the following specified procedures:

- Removal of impacted, buried or unerupted teeth
- Removal of roots
- Removal of solid odontomes
- Apicectomy
- New or repair of bridge work
- New or repair of crowns
- Root canal treatment
- New or repair of upper or lower dentures
- Removal of wisdom teeth (whether performed in hospital or in dental surgery, whether performed by a dental practitioner, specialist, or an oral or maxillofacial surgeon)

This benefit excludes orthodontic treatment, routine treatment and dental implants.

For this benefit, your policy excess does not apply.

A 6 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

Dental 3 — Orthodontic dental treatment: This benefit must be purchased in conjunction with routine dental or major restorative dental treatment. It covers the fees and associated costs of a dental practitioner carrying out orthodontic treatment in a dental surgery. This benefit is limited to any member up to and including 18 years of age.

For this benefit, your policy excess does not apply.

A 6 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

Dental 4 — Dental implants: The treatment and cost of dental implants.

For this benefit, policy excess does not apply.

A 6 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

Dental 5 — Combined routine & restorative dental: Fees of a dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment is defined as:

- Examinations
- Tooth cleaning
- Normal compound fillings
- Simple non-surgical extractions

Restorative dental covers the fees of a dental practitioner and associated costs for the treatment of the following specified procedures:

- Removal of impacted, buried or unerrupted teeth
- Removal of roots
- Removal of solid odontomes
- Apicectomy
- New or repair of bridge work
- New or repair of crowns
- Root canal treatment
- New or repair of upper or lower dentures
- Removal of wisdom teeth (whether performed in hospital or in dental surgery, whether performed by a dental practitioner, specialist, or an oral or maxillofacial surgeon)

This benefit excludes orthodontic treatment and dental implants.

For this benefit, your policy excess does not apply.

A 6 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

Dental 6 — Combined routine & restorative dental with orthodontics: Fees of a dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment is defined as:

- Examinations
- Tooth cleaning
- Normal compound fillings
- Simple non-surgical extractions

Restorative dental covers the fees of a dental practitioner and associated costs for the treatment of the following specified procedures:

- Removal of impacted, buried or unerrupted teeth
- Removal of roots
- Removal of solid odontomes
- Apicectomy
- New or repair of bridge work
- New or repair of crowns
- Root canal treatment
- New or repair of upper or lower dentures
- Removal of wisdom teeth (whether performed in hospital or in dental surgery, whether performed by a dental practitioner, specialist, or an oral or maxillofacial surgeon)

Orthodontic treatment covers the fees and associated costs of a dental practitioner carrying out orthodontic treatment in a dental surgery to any member up to and including 18 years of age.

This benefit excludes dental implants.

For this benefit, your policy excess does not apply.

A 6 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

Dental 7 — Combined routine & restorative dental

with orthodontics and dental implants: Fees of a dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment is defined as:

- Examinations
- Tooth cleaning
- Normal compound fillings
- Simple non-surgical extractions

Restorative Dental covers the fees of a dental practitioner and associated costs for the treatment of the following specified procedures:

- Removal of impacted, buried or unerrupted teeth
- Removal of roots
- Removal of solid odontomes
- Apicectomy
- New or repair of bridge work
- New or repair of crowns
- Root canal treatment
- New or repair of upper or lower dentures
- Removal of wisdom teeth (whether performed in hospital or in dental surgery, whether performed by a dental practitioner, specialist, or an oral or maxillofacial surgeon)

Orthodontic treatment covers the fees and associated costs of a dental practitioner carrying out orthodontic treatment in a dental surgery to any member up to and including 18 years of age.

Dental implants covers the treatment and cost of dental implants.

For this benefit, your policy excess does not apply.

A 6 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

Outpatient direct settlement network — Nil excess:

Outpatient consultations are available on a nil excess basis where treatment is received in network. The policy excess applies where consultations take place out of network.

Outpatient consultations for the following benefits are covered subject to their inclusion in your plan, and up to the value of cover selected in your plan:

- i) Complications of pregnancy
- ii) Congenital anomalies
- iii) CT and MRI scans
- iv) Hormone replacement therapy (HRT)
- v) Oncology
- vi) Outpatient care
- vii) Outpatient psychiatric treatment
- viii) Outpatient surgery

Extended evacuation: This benefit covers the evacuation costs of a member in the event emergency treatment is not readily available at the place of incident, to the nearest appropriate medical facility, country of residence, country of nationality or country of the member's choice for the purpose of admission to hospital as an inpatient or day patient, including the cost of one other person to travel with the member as an escort if medically necessary.

Evacuation is subject to written agreement from us prior to travel and certified instructions to us from the attending medical practitioner or specialist including confirmation that the required treatment is unavailable in the place of incident. The member's country of choice is limited to appropriate medical facilities being in place and where it is medically suitable at our discretion. This option is not operative where travel is undertaken against the advice of our medical advisors or where the nominated country does not have the appropriate facility to treat the medical condition. Our medical advisors will decide the most appropriate method of transportation for the evacuation.

This benefit excludes any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts, all maternity and childbirth costs except where these are covered under the benefit for Complications of Pregnancy, and elective treatment in the USA unless this benefit has been purchased and appears on the member's benefits schedule.

Out of country transportation: The costs of moving an insured person in the event of medically necessary non-emergency treatment not being readily available at the place of the incident, to the nearest centre of medical excellence, within the area of cover, for the purpose of admission to hospital as an inpatient or day patient (excluding all maternity or childbirth costs, except for Complications of Pregnancy) and/or for the purpose of seeking any medically necessary inpatient, day patient or outpatient treatment. Cover under this benefit is subject to written agreement from us prior to travel and certified instructions from the attending medical practitioner or specialist including confirmation that the required treatment is unavailable at the place of incident. Cover is provided for:

- i) Evacuation costs (restricted to economy class flight tickets only) including the costs of one other person to travel with the member as an escort, if medically necessary.
- ii) Travel to and from medical appointments when treatment is being received as a day patient.
- iii) For an accompanying person to travel to and from the hospital to visit the member following admission as an inpatient.
- iv) Economy class airline ticket to return the member and any escort to the country of residence or to the country where evacuation occurred.
- v) Non-hospital accommodation for the member and escort for immediate pre- and post-hospital admission periods provided that the member is under the care of a specialist.

Hearing benefit: The cost of one annual hearing test and hearing aids.

For this benefit, your policy excess does not apply.

Infertility treatment (minimum of 10 employees required):

Ovulation induction induced via certain oral or injectable infertility medication, artificial insemination, and advanced reproductive technology (ART) procedures and In vitro fertilisation (IVF) with embryo transfer.

This benefit requires preauthorisation prior to any treatment taking place and approval of medication and procedures to be undertaken.

The following exclusions apply:

- Couples in which one of the partners has undergone a sterilisation procedure with or without a surgical reversal.
- Females with FSH levels 19 mIU/ml or greater on day three of their menstrual cycle, or who manifest a positive Clomid challenge.
- Charges for: the purchase and storage of donor sperm, the care of the donor required for donor egg retrievals or transfers, Cryopreservation or storage of cryo-preserved embryos.
- ART for women without male partners who have not had at least 12 cycles of donor insemination prior to enrolling in the infertility programme for ART (6 cycles if the member is age 35 or older).
- Charges associated with a gestational carrier programme (surrogate parenting) for either the member or the gestational carrier.

Routine pregnancy: Costs associated with normal pregnancy and childbirth, including normal deliveries as a result of infertility treatment (assisted conception), voluntary caesarean section costs and medically necessary caesarean costs due to any non-medical previous caesarean sections.

This benefit also covers the cost of pre-natal checkups, and post-natal checkups for up to six weeks after delivery, prescribed pre-natal vitamins, and delivery costs, including qualified Midwives. All costs relating to complications of pregnancy or childbirth following infertility treatment (assisted conception) will be limited to this benefit.

This benefit extends to include only the following for a new born child:

- One physical examination;
- Vitamin K, hepatitis B and BCG vaccinations;
- Circumcision;
- Routine blood tests for PKU, congenital hypothyroidism and G6PD;
- One hearing examination; and
- Reasonable accommodation costs for no more than four nights, if the mother is admitted and not suffering any complications.

The policy excess does not apply to this benefit. A 12 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

The newborn must be enrolled as a member within 30 days after birth in order to be eligible for any benefits (as per policy terms) after the first 24 hours.

Traditional Chinese or Ayurvedic medicine: This benefit covers the cost of treatment administered by a recognised traditional Chinese or Ayurvedic medical practitioner.

For this benefit, your policy excess does not apply.

USA elective treatment:

- i) Inpatient or day patient treatment received in-network
- ii) Inpatient or day patient treatment received out-of-network (subject to 50% coinsurance)
- iii) Outpatient treatment

All planned inpatient and day patient treatment must be notified to us prior to commencement of treatment.

The International Healthcare Plan (IHP) does not comply with the Patient Protection and Affordable Care Act (U.S. healthcare reform), and cannot be used to satisfy any requirements for health insurance cover mandated therein.

Vision care: The cost of one routine eye exam per period of cover and the purchase of vision hardware, when the member's prescription has changed. Vision hardware covers prescribed glasses or contact lenses.

For this benefit, your policy excess does not apply.

Wellness option 1: This benefit covers the cost of:

- i) Routine medical checkups and associated tests. Such routine checkups/tests include: blood and cholesterol checks, height/weight body mass index, resting blood pressure, urine analysis, cardiac examination, exercise electrocardiogram (ECG), other vital organ function tests, and chest x-ray.
- ii) Well-baby checks, effective from 24 hours after birth and up until the child's second birthday and as recommended by a medical practitioner or specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, hemoglobin and other blood tests, including tests to screen for sickle hemoglobinopathy.

For this benefit, your policy excess does not apply.

Wellness option 2: This benefit covers the cost of:

- i) Bilateral mammogram/breast examination and routine gynaecological tests including PAP tests.
- ii) Testicular/prostate examination/PSA/DRE tests.
- iii) Routine medical checkups and associated tests. Such routine checkups/tests include: blood and cholesterol checks, height/weight body mass index, resting blood pressure, urine analysis, cardiac examination, exercise electrocardiogram (ECG), other vital organ function tests, and chest x-ray.
- iv) Well-baby checks, effective from 24 hours after birth and up until the child's second birthday and as recommended by a medical practitioner or specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, hemoglobin and other blood tests, including tests to screen for sickle hemoglobinopathy.

For this benefit, your policy excess does not apply.

Wellness option 3 preventive screening: Preventive screening for members who are deemed at high risk of cancer because of family history of familial adenomatous polyposis or hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease, family history of breast, ovarian, endometrial, colon cancer or polyps, or a background, ethnic or lifestyle, such that the health care provider treating the member believes he or she is at elevated risk, shall include a screening by colonoscopy, barium enema or any combination of the most reliable, medically recognized screening tests available.

For this benefit, your policy excess does not apply.

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), with the exception of congenital 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. 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.
5. Preventive medicines, and routine tests and physical examinations by a medical practitioner, including gynecological 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.
6. 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.
7. Rehabilitation except as expressly provided under the benefit for Inpatient Care, Rehabilitation.
8. Treatment received in health spas, nature cure clinics, spas, or similar establishments. Services such as massages, hydrotherapy, reiki, or other non-medical treatments. Treatment given at establishments or a hospital where that facility has become the member's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.
9. Cosmetic treatment, and any consequence thereof.
10. Any treatment for weight loss or weight problems including but not limited to bariatric procedures, diet pills or supplements, health club memberships, diet programs and treatment in a residential treatment facility for eating disorders. Any complications arising from weight loss or other excluded procedures are not covered.
11. Alternative therapy, including, but not limited to, hypnotherapists and lactation examiners.
12. 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.
13. Voluntary caesarean section costs or medically necessary caesarean section costs due to any previous voluntary caesarean sections undertaken, unless the benefit for Routine Maternity has been purchased.
14. Pregnancy terminations on non-medical grounds, antenatal classes or midwifery costs when not associated with delivery.
15. 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.

16. 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. Where this has been purchased, complications of pregnancy and Routine Pregnancy costs resulting from infertility treatment (assisted conception) will be limited to the amount of your selected Routine Pregnancy benefit.
17. Treatment of impotence or any related condition or consequence thereof.
18. Treatment directly or indirectly associated with a sex change and any consequence thereof.
19. Venereal disease or any other sexually transmitted diseases or any related condition except for those payable under the AIDS benefit.
20. 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.
21. 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).
22. 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.
23. Suicide or attempted suicide, bodily injury or illness, which is willfully self-inflicted or due to negligent or reckless behaviour.
24. Any injury sustained directly or indirectly as a result of the member acting illegally or committing or helping to commit a criminal offence.
25. Costs and expenses incurred where a member has travelled against medical advice.
26. 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).
27. 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.
28. Treatment for sleep related breathing disorders, including snoring, fatigue, jet lag or work-related stress or any related condition.
29. Dietary supplements and substances that are available naturally and that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic substances, and infant formula given orally. We will however pay for prescribed pre natal vitamins under the Routine Pregnancy benefit if purchased.
30. Home visits by a medical practitioner, specialist or qualified nurse unless specifically agreed by us in writing prior to consultation.
31. 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.
32. 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.
33. The following hazardous activities are excluded: 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-site; and arctic or antarctic expeditions.
34. Treatment for complications arising from any uncovered and/or excluded procedures or treatments.
35. Self-treatment, or treatment provided by a Direct Family Member. This includes but is not limited to prescribed medication, diagnostic tests and surgical procedures.
36. All benefits are excluded unless they appear on your benefits schedule.

Complaints procedures

If you wish to make a complaint

We endeavor to meet our customers' expectations at all times. We understand that from time to time complaints may arise. Our complaints handling procedures are based on the rules prescribed by the General Insurance Association of Singapore and our aim is to resolve any complaints that we receive both fairly and promptly.

Who should I contact with a complaint?

Complaints Resolution Team

Aetna Insurance (Singapore) Pte. Ltd.

112 Robinson Road

#09-01 Robinson 112

Singapore 068902

Telephone (Toll Free from Singapore): 800-110-1951

Telephone (Toll Free from Other Countries Using AT&T Access Codes*): +1-855-532-5085

Email: AetnaInternationalComplaints&Appeals@aetna.com

Summary of our complaints handling procedures

Your complaint will:

- be acknowledged promptly, within 3 working days, confirming who will be responsible for investigating your complaint.
- be competently, efficiently and impartially, ensuring that we keep you informed on progress.
- be assessed fairly, consistently and promptly.
- within 17 working days, receive either a letter giving the status of your complaint or a final response detailing the outcome of the investigation and, if you purchased your cover in a country where such a service is available, offering you the right to refer your complaint to an Ombudsman service should you remain dissatisfied.

If the outcome of your complaint is not handled to your satisfaction, you can write to our principal officer to appeal. If this is the case, you will receive a response to your appeal within 14 working days.

Insurance Disputes Resolution Scheme

If you are still dissatisfied with the Chief Executive's response to your dispute, we will refer you to the following independent dispute resolution organisation:

Contact details:

Financial Industry Disputes Resolution Centre Ltd (FIDReC)

112 Robinson Road #13-03

Singapore 068902

Telephone: 63278878

Fax : 63278488

Email: info@fidrec.com.sg

Website: www.fidrec.com.sg

Alternative Dispute Resolution

Below are listed methods of alternate dispute resolution available to you. Please consider that these methods of dispute resolution are subject to fees to which you may be liable. Therefore we recommend that your dispute be primarily referred to the Financial Industry Disputes Resolution Centre (details above) before any alternate dispute resolution is sought.

Mediation (Singapore Mediation Centre)

Where claims are small, expensive and prolonged litigation can exhaust time and resources, mediation may be the solution to take control of the outcome of these disputes in a timely and cost-efficient manner.

Contact Details:

Singapore Mediation Centre

1 Supreme Court lane, Level 4

Singapore 178879

Tel: 6332 4366 / Fax : 6333 5085

E-mail: enquiries@mediation.com.sg

Arbitration (Singapore International Arbitration Centre)

Any dispute, difference or question which may arise at any time hereafter in relation to the true construction of the policy or our respective rights or liabilities under this policy, will be referred to arbitration in Singapore and Singapore laws will apply. The arbitration will be heard by a single arbitrator to be agreed between us and you within 14 business days of the commencement of the arbitration.

Contact Details:

Singapore International Arbitration Centre

32 Maxwell Road#02-01,

Maxwell Chambers Singapore 069115

Tel: +65 6221 8833

Fax: +65 6224 1882

Where your complaint relates to the services provided by another firm we shall advise you of this and forward your complaint to the other firm for resolution.

Where we and another firm are jointly responsible for your complaint we shall ensure that you are informed of this and each company will contact you directly in relation to the complaint for which it is responsible.

Call us

Toll-free from Singapore: 800-110-1951

Toll-free from other countries using AT&T access codes*:
+1-855-532-5085

Toll: +852-3071-5022

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