aetna™

Cognizant

Get to know your health insurance benefits

Cognizant Handbook

Emerald – with flex

For plans with a start date on or after 1 November 2021

Visit **www.aetnainternational.com**

M003-298E-011121

Now that you're an Aetna International member, it's time to get to know your benefits. **This Handbook will help make it easy.**

Explore the benefits of being a member
What to do right now

Your benefits are designed to connect you with expansive global resources that put you in control of your health. **It starts with choice, comfort, care and an unwavering commitment to keep you at the centre of everything we do.**

Get connected

Health Hub

Now is a good time to register for the Health Hub. The site gives you the tools you'll need to manage your health benefits. You can register in just a few steps by visiting **www.aetnainternational.com** and clicking "*Secure login*" under the "*Aetna Member*" section. You'll need to enter your name, date of birth, and your member ID number.

You can use the website to:

- Submit and track claims
- Find nearby doctors and hospitals
- Browse a library of health topics
- View your plan documents

International Mobile Assistant

If you have a smartphone, you can download helpful apps, such as our International Mobile Assistant, which makes it easy to manage your benefits on the go. You can also download your e-Card using the app. Seach 'Aetna' in the iTunes or Google Play store to get started.

Your Member ID Card

The Member ID Card is your key to quality health care. Make sure to keep the card in a safe place – you'll be asked to present it whenever you receive health care treatment. You may also need to have it handy when registering for the Health Hub or calling Member Services.

Things to note for your next doctor visit

You may need to obtain prior approval (preauthorisation) for certain types of treatment. In these instances, it's important to start the process early to prevent delays or denial of your claims.

You must obtain preauthorisation for the following outpatient treatments:

- MRI, PET and CT scans
- Physiotherapy if you receive more than 10 sessions

If you do not obtain preauthorisation for these outpatient treatments, we reserve the right to decline your claim. On appeal, if we do reimburse, it would be capped at 80% of the reimbursable cost.

We recommend obtaining preauthorisation for the following so that we can directly pay the medical/service provider on your behalf:

- Medical evacuation
- Inpatient or daycare treatment admission
- Compassionate emergency visit
- Preparation or transportation of body or mortal remains
- Psychiatric treatment
- Prescription for more than three months' supply of drugs for the management of a chronic medical condition

All preauthorisations must be requested before treatment or services are received or costs are incurred. If it is not possible to request preauthorisation for an emergency, please be sure to notify us within the first 24 hours.

You can find full details in your Claims procedures or in the Claims Centre of the Health Hub.

> Ready to learn more about your benefits? Keep reading to find all the details you need.

Area of cover	Worldwide excluding US
OVERALL PLAN LIMIT (PER MEMBER PER POLICY YEAR)	
Reasonable costs will be paid for **you** up to the overall **plan** limit in the **plan year**. **We** will not pay any more than the overall **plan** limit for any one or more claims on any one or more of the **benefits** below. Where a **benefit** limit is shown as 'Paid in full', this is still subject to the overall **plan** limit. Unless stated, all **benefit** limits shown apply for the **plan year**.	SGD 200,000
INPATIENT AND DAYCARE TREATMENT	
Medical costs including intensive care costs, theatre costs, **hospital** accommodation, **medical practitioners'** and **specialists'** fees, anaesthetists' fees, nursing fees, appliances and prescribed drugs and dressings.	Paid in full
MRI, PET and CT scans, X-rays, pathology and other **diagnostic tests and procedures**.	
Reconstructive surgery to restore natural function or appearance within 12 months of an **accident** or surgery.	
Speech, language, physiotherapy and occupational therapy as part of your **inpatient treatment**.	
Treatment for diagnosed **congenital abnormalities** and any **related medical conditions**. This includes **palliative treatment** and care during the end stages of a **congenital abnormality** or any **related medical condition**.	
Kidney dialysis.	
Psychiatric **treatment** and psychotherapy. This **benefit** is available for up to 30 days in the **plan year**.	Paid in full up to 30 days
Medical services of a nurse as part of **your inpatient** or **daycare treatment** when these are received in **your** home instead of in hospital.	Paid in full up to 2 weeks
All **treatment** needed for **acute medical conditions** that begin before the **member** is eight days old, if the **member** was conceived by natural conception.	Paid in full
Treatment when your **medical condition** is an **emergency** and **you** are outside your **area of cover**.	Paid in full
REHABILITATION This **benefit** is only available if: • **you've** received **inpatient treatment** for three or more consecutive days for the same **medical condition**, • **you've** stayed in **hospital** for three or more consecutive nights for the same **medical condition**, • your **inpatient treatment** was covered under Inpatient and daycare treatment, • a **medical practitioner** or **specialist** has referred **you** for rehabilitation, and • your rehabilitation starts: – after **you're** discharged from hospital following **your inpatient treatment**, or – when **you're** transferred to a rehabilitation unit following **your inpatient treatment**. **Your** first session must be no more than 14 days after **you're** discharged or transferred. This **benefit** covers inpatient, daycare physiotherapy, speech and language therapy and occupational therapy. **We'll** also pay for accommodation costs at the rehabilitation unit when medically necessary.	Paid in full up to 30 days
PARENT ACCOMMODATION	
Hospital accommodation costs for a parent or legal guardian to stay with the **member** if they are aged 17 or under and receiving **inpatient treatment** that **we** cover under Inpatient and daycare treatment.	Paid in full
CANCER CARE	
All **inpatient** and **outpatient treatment** for, or related to, a diagnosed cancer. This includes **palliative treatment** and care during the end stages of a cancer.	Paid in full
KIDNEY DIALYSIS	
All **inpatient** and **outpatient treatment**, including **palliative treatment** and care, for kidney dialysis.	Paid in full

OUTPATIENT TREATMENT	
Medical practitioners' and **specialists'** fees (consultations only)	Paid in full (applicable only if outpatient limit is exhausted)
Access to unlimited virtual consultations with a licensed **medical practitioner** via MyDoc, provided by Aetna	Included
Outpatient Limit: **We** will pay up to the overall outpatient limit for any one or more claims on any one or more of the **benefits** below.	Paid up to SGD 5,000
Surgical procedures.	Paid up to Outpatient Limit
Medical practitioners' and **specialists'** fees, prescribed drugs and dressings, X-rays, pathology and **diagnostic tests and procedures**.	
Treatment for any one or more **medical conditions** that are an **emergency** when the **treatment** is received in a **hospital**.	
Physiotherapy when referred by a **medical practitioner** or **specialist**. Further medical information may be needed if **you** receive further **treatment** after **you** have completed the number of sessions that were referred by the **medical practitioner** or **specialist**. (For up to 10 sessions)	
PET/CT/MRI scans.	
Hormone replacement therapy for symptoms of the menopause.	
Treatment for diagnosed **congenital abnormalities** and any **related medical conditions**.	
Treatment when **your medical condition** is an **emergency** and **you** are outside your **area of cover**.	
REHABILITATION This **benefit** is only available if: • **you've** received **inpatient treatment** for three or more consecutive days for the same **medical condition**, • **you've** stayed in **hospital** for three or more consecutive nights for the same **medical condition**, • **your inpatient treatment** was covered under Inpatient and daycare treatment, • a **medical practitioner** or **specialist** has referred **you** for rehabilitation, and • your rehabilitation starts: – after **you're** discharged from **hospital** following your **inpatient treatment**, or – when **you're** transferred to a rehabilitation unit following your **inpatient treatment**. **Your** first session must be no more than 14 days after **you're** discharged or transferred. This **benefit** covers **outpatient** physiotherapy, speech and language therapy and occupational therapy.	Paid up to Outpatient Limit for up to 30 days (Outpatient benefits only)
Psychiatric **treatment** and psychotherapy. This benefit extends to cover Applied Behavioural Analysis (ABA) for the treatment of Autism.	Paid up to SGD 1,500 (forms part of outpatient limit)
Speech and language therapy and occupational therapy including for the **treatment** of Autism.	Paid up to SGD 1,500 (forms part of outpatient limit)
Podiatry, osteopathic, acupuncture, homeopathic **treatment** and chiropractic **treatment**. Further medical information may be needed after four sessions for any one **medical condition**.	Paid up to SGD 700 (forms part of outpatient limit)
Traditional Chinese medicine, ayurvedic medicine. Further medical information may be needed after any four sessions for any one **medical condition**.	
Adult and child vaccinations.	Paid up to SGD 750 (forms part of outpatient limit) + Flex limit

OUTPATIENT TREATMENT CONTINUED	
DURABLE MEDICAL EQUIPMENT (DME) **We'll** cover costs for: • Items a **medical practitioner** or **specialist** prescribes which are needed to deliver prescribed drugs and apply dressings • Buying and fitting of devices or items **medically necessary** for **treatment** including spinal supports, orthopaedic braces and air cast boots • The rental or initial purchase of crutches or a wheelchair if **medically necessary** • The initial buying and fitting of external prostheses • The buying and fitting of **medically necessary** orthotic supplies, including insoles and orthotic supports	Paid up to SGD 350 (forms part of outpatient limit) + Flex limit

ORGAN TRANSPLANTS	
Kidney, pancreas, liver, heart, lung, allogenic bone marrow or autologous bone marrow transplants and any related **treatment**. Pre-authorisation is required.	Paid in full
Costs for the surgical removal of an organ from the donor, including pre-operative consultations and post-operative follow-up, and management of any post-operative complications. Cover is only available under this **benefit** if **you** are the recipient of the organ and the organ transplant is covered under the section above.	Paid in full

TERMINAL CARE	
Palliative treatment and care for a **medical condition** which is diagnosed as **terminal**.	Paid in full

MEDICAL EVACUATION	
Medical Evacuation Limit: **We** will not pay any more than the overall medical evacuation limit for any one or more claims on any one or more of the **benefits** below.	Paid up to SGD 50,000
The costs to transport **you** to the nearest appropriate medical facility when **your medical condition** is an **emergency** and **we** agree appropriate **treatment** is not available locally. This **benefit** extends to the costs for **emergency treatment you** receive during the journey. If **we** have transported **you** outside your **area of cover**, **we**'ll pay any related costs **you** incur in the country **you're** evacuated to under the sections of your **Benefits schedule** that would normally apply when **you're** within your **area of cover**.	Paid up to Medical Evacuation Limit
Economy class travel costs for **you** to go back to **your** choice of **your country of residence**, or **your home country**, after **your emergency** medical evacuation that was covered under this **plan**.	
Costs of one **dependant** or companion having to accompany **you** or to travel at the same time if they are not able to accompany **you** during the actual **emergency** medical evacuation. This **benefit** will only become available if **your medical condition** is critical or **you're** expected to stay in **hospital** for seven or more nights. For the duration of **your** evacuation and period of admission **we'll** cover: (i) • Costs for return economy class travel, including taxi transfers to and from the hotel on arrival and departure (ii) • A taxi from the hotel to the hospital, and back, once a day • Reasonable overnight accommodation costs including breakfast	(i) Paid up to Medical Evacuation Limit (ii) Paid up to SGD 200 per day (capped at SGD 6,250 per evacuation, subject to Medical Evacuation Limit)
Costs for medical evacuations do not extend to air-sea rescue, or any mountain rescue unless related to a **medical condition you** suffer at a recognised ski resort or similar winter sports resort.	

AMBULANCE	
Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local **hospital** because of an **emergency** or due to **medical necessity**.	Paid in full
Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local **hospital**. This **benefit** is only available when **your medical condition** is an **emergency** and **you** are outside **your area of cover**.	Paid in full
Costs for local ambulances do not extend to air-sea rescue, or any mountain rescue unless related to a **medical condition you** suffer at a recognised ski resort or similar winter sports resort.	

MORTAL REMAINS	
In the event of death from an **eligible medical condition**, **we** will cover the transportation of the body of a **member**, or his/her ashes, to the country of nationality or **country of residence** and burial and cremation costs at the place of death in accordance with reasonable and customary practice. Necessary burial fees include: • 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 Necessary cremation fees include: • The cremation fee • The cost of any doctor's certificates • The cost of removing a pacemaker or other medical device which must be removed before the cremation This **benefit** does not extend to costs for: • 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 This **benefit** does not apply in the event of death within the home country.	Paid up to SGD 6,250

DENTAL TREATMENT	
Outpatient dental treatment for accidental damage to sound, **natural teeth**, except when the damage is caused through eating. Cover is only available when **treatment** for the accidental damage is received within ten days of the **accident**. This **benefit** also includes one follow-up consultation within 30 days of the **accident**. This **benefit** includes the cost to supply and fit **dental** implants.	Paid up to Outpatient Limit
Routine **outpatient dental treatment**, including **treatment** for accidental damage to sound, **natural teeth** when the damage is caused through eating. This **benefit** covers **dental** examinations, scraping, cleaning and polishing, gum treatment, X-rays, composite fillings and simple non-surgical extractions only.	Paid up to SGD 1,500
Major restorative **dental treatment**, including **treatment** for accidental damage to sound, **natural teeth** when the damage is caused through eating. This **benefit** covers: • Surgical extractions, including wisdom teeth • Root canal **treatment** • The cost to supply, fit and repair crowns, bridges and dentures • X-rays needed to support major restorative **dental treatment**	

FLEX	
Cover is available after **you've** had 90 days' continuous cover from the date that this **benefit** was first included in **your plan**.	Paid up to SGD 350
Flex Limit covering: Wellness • Health Supplements prescribed by medical practitioners and specialist • One Sports Health Watch per member (Limited to 2 per family) • Nutritional Counselling (New) • Weight Management Counselling (New)	
Sports-related Membership/Booking Fees • Gym membership • Baby Gym membership • Booking of sports facilities such as tennis court • All Sports coaching lessons/ group class such as swimming class	
Medical-related Expenses and Dental Treatments • Outpatient Medical Expenses (New) - only applicable for members that maxed out their OP benefit limit. • Durable Medical Equipment (DME) • **Orthodontic** Related Treatments (braces) This **benefit** covers: • **Orthodontic** examinations • Costs to supply, fit and repair **orthodontic** devices or items • X-rays needed to support **orthodontic** treatment • Surgical and non-surgical extractions needed as part of your **orthodontic** treatment	
Health Screening / Vaccinations • Health Screening or Preventive Health Exams • Adult and Child Vaccinations • Well Child Tests • Preventative services for sight and hearing in the plan year for a child if they are aged 15 or under	
Optical Related Expenses Costs of prescription: • Contact lenses • Spectacles • Spectacle lenses • Spectacle frames This **benefit** also covers the costs of consultations and preventative eye checks.	

PREGNANCY AND CHILDBIRTH	
Costs for: • Antenatal checkups for an uncomplicated pregnancy. • Antenatal vitamins • Delivery costs, nursing fees and **hospital** accommodation costs for uncomplicated childbirth • Postnatal checkups • **Hospital** accommodation costs for **your** newborn to stay with **you** for up to four nights immediately after his or her birth. **We'll** also pay the following routine costs for the newborn for the first 30 days after his or her birth, even if **you** do not add the newborn to **your plan**: • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination	Paid up to SGD 10,000 20% **coinsurance**
Treatment for medical maternity complications during pregnancy or childbirth, if the pregnancy is the result of an assisted conception. **We'll** also cover the following routine costs for the newborn for the first 30 days after his or her birth, even if **you** do not add **your** newborn to **your plan**: • **Hospital** accommodation costs for **your** newborn to stay with **you** immediately after a complicated childbirth • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination	
Voluntary C-Section • Cost of a caesarean section that is not **medically necessary**. **We'll** also pay the following routine costs for the newborn for the frst 30 days after his or her birth, even if **you** do not add the newborn to **your plan**: • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination	Paid up to SGD 25,000 20% **coinsurance**
Treatment for medical maternity complications during pregnancy or childbirth. **We'll** also cover the following routine costs for the newborn for the first 30 days after his or her birth, even if **you** do not add your newborn to **your plan**: • **Hospital** accommodation costs for **your** newborn to stay with **you** immediately after a complicated childbirth • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD • One hearing examination	Paid in full

HOSPITAL CASH BENEFIT (FOR SINGAPORE GOVERNMENT RESTRUCTURED HOSPITALS)	
We'll pay **you** for each night you stay in a **Singapore government restructured hospital** for **inpatient treatment** if **we** would normally cover the **treatment** or services **you** receive during **your** stay under this **plan**.	SGD 150 paid to you for each night (up to 20 nights)

DEDUCTIBLES	
Maternity **coinsurance** on non-complicated pregnancy. This **coinsurance** is applied to each claim.	20% **coinsurance**

HEALTH MANAGEMENT SERVICES	
Chronic condition and disease management to provide tailored information and access to a nurse to discuss **your** health.	Included

AETNA SECURITY ASSISTANCE	
24/7 personal security information and telephone support for all **your** travel safety queries. Log in to **your** Health Hub to find out more and to register for this service.	Included

Plan overview

This Handbook, together with your Benefits schedule, explains what is, and is not, covered under the plan.

For information on how to make a claim please refer to your Claims procedures.

If you have any questions about the information in the plan documentation or any questions you think it does not answer, please contact us and we will be more than happy to help.

Some words and phrases used in this Handbook, your Benefits schedule and your Claims procedures have specific meanings. We have highlighted them in bold print and defined them in the 'Definitions' section of this Handbook.

A plan is our contract of insurance with the planholder, providing cover as detailed in the plan documentation. In order to fully understand a plan, these documents must be read together.

We can change any of the following at the beginning of each plan year:

- Conditions, exclusions and any other terms in this Handbook
- Premiums and any discounts or surcharges

We will tell the plan sponsor about any changes before the plan renewal date.

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

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.

About the plan

Member eligibility

Our plans are available to people of most nationalities, depending on where they reside. We cannot cover people subject to certain sanctions or people residing in certain sanctioned locations. Our plans are not available to citizens of the United States (US) who reside in the US. Please contact us if you need further information.

Plans may not meet specific visa requirements. Cover may also be illegal under local laws. It is the plan sponsor's responsibility to ensure that any plans chosen meet your needs.

If you are a citizen of the US and spend or plan to spend any time in the US during a plan year please refer to plan term P10 in this Handbook.

You must have continuous membership under the plan.

If you will be aged over 65 at your plan start date, you will be subject to medical underwriting and must answer some medical questions for us to consider your eligibility for cover. Once accepted by us, no further medical underwriting will be applied whilst you remain a continuous, eligible, insured member.

To be eligible for this plan, main members must be:

- an employee of the plan sponsor,
- at least 18 years old, and
- eligible due to their position within the plan sponsor's organisation.

All dependant children on a plan must be unmarried. Dependant children aged 18 to 25 must be in continuous full-time education at their start date. If a dependant child does not meet these conditions then they cannot be covered under the plan. Please contact us for alternative cover options.

We may provide cover under our plans with any special terms that we may set. Any special terms will be shown on the Certificate of insurance.

Plan benefits and currency

The plan sponsor has chosen the plan level and benefits, that are available to you. Our plans are provided on the basis of an employer-paid annual contract only.

The plan sponsor has chosen the currency of your plan from the currencies available. They chose this at application or renewal and it will apply throughout the entire plan year.

If more than one currency is shown on your Benefits schedule, the benefit limit shown in the same currency as the plan will apply to you.

Joining the plan

Your plan administrator must contact us to add you to the plan that is available to you. All material facts about you must be given to us and you cannot be added until we agree to cover you. We must be told about any treatment you have planned or are aware of, see E33 in the 'Exclusions' section for more information.

You must be added to the plan within 30 days of becoming eligible for cover. You may have to complete a Group member application.

We will not backdate cover under any circumstances.

Your start date will be advised to you by your plan administrator once we have agreed to cover you.

We will send Member ID Cards for you and each of your dependants covered under the plan. Any other documents you need, including Certificates of insurance, will either be available online through the Health Hub or sent in a printed member pack.

Adding dependants

Your plan administrator must contact us to add your dependant to the plan that is available to them. All material facts about your dependant must be given to us and they cannot be added until we agree to cover them. We must be told about any treatment your dependant has planned or are aware of, see E33 in the 'Exclusions' section for more information.

Dependants must be added to the plan within 30 days of becoming eligible for cover. You and your dependant may have to complete a Group member application. See the 'Member eligibility' section for more information.

Dependants must have the same plan level, area of cover, optional benefits and deductibles as their main member.

If your dependant is a newborn child and they are being added before they are 31 days old, we will not exclude pre-existing medical conditions under the plan and their date of joining will be their date of birth.

We will not backdate cover under any circumstances.

Your dependant's start date will be advised to you by your plan administrator once we have agreed to cover them.

We will send a Member ID Card for your dependant. Any other documents, including a revised Certificate of insurance, will either be available online through the Health Hub or sent in a printed member pack.

Leaving the plan

With our agreement the plan sponsor may remove members from a plan after the plan start date. If you are removed from a plan, your end date will be the date that we receive the request, or a future date the plan sponsor has given.

You must leave the plan if you are no longer eligible for cover, see the 'Member eligibility' section for more information. If you wish to remove a dependant please contact your plan administrator.

If a main member is removed from a plan, all of their dependants will also be removed.

Premiums may change in line with any agreed requests.

When you leave any plan, you must return your Certificate of insurance to your plan administrator. You must also return your Member ID Card if you leave the plan.

We will send a revised Certificate of insurance if a dependant has been removed.

If you are leaving the plan, you may apply for an individual plan. Please contact your plan administrator or us to discuss the options available to you.

Making plan changes

The following cannot be changed during the plan year:

- The plan level of any plan
- Optional benefits on any plan
- Deductibles on any plan
- The currency of any plan
- The terms contained in this Handbook

If a main member needs to change their area of cover on the plan, they must tell the plan administrator. We will need to know the reason for the change in circumstances. With our agreement this change can be made at any time during the plan year. We will make this change from the date the plan administrator tells us or any future date they have given.

If a **dependant** lives in a different country to their **main member** please contact the **plan administrator** for more information.

All **material facts** relating to any change must be given to **us**.

We will send a revised **Certificate of insurance** if **your** new address is in a different country or **your area of cover** changes. If **your area of cover** changes, **we** will also send a revised **Member ID Card**.

Premiums, taxes and **benefit** limits may change in line with any agreed requests.

Plan cancellation and suspension

If the **plan** is cancelled by the **plan sponsor** or **us** for any reason **your plan administrator** will let **you** know.

After a **plan** is cancelled **you** cannot make a claim. Please return **your Certificate of insurance** and **Member ID Card** to the **plan administrator**.

If a **Member ID Card** is used to obtain **treatment** at a **direct billing** facility after the **plan** has been cancelled, **you** or the **plan sponsor** will be responsible for paying any costs to the **treatment** provider. **We** will not be responsible for any costs after cover has been cancelled.

If a **plan** is suspended by **us** for any reason, claims will not be approved or paid until the suspension is lifted. **We** will tell the **plan administrator** that a **plan** is suspended. **We** will tell **you** if the **plan** is suspended when **we** assess **your** claim.

Clinical Policy Bulletins

We have developed Clinical Policy Bulletins (CPBs) to assist in administering **our plans**. CPBs express **our** determination of whether certain **treatments**, services or costs are **medically necessary**, unproven, experimental, investigational or cosmetic. They are based on objective and credible s**our**ces, including scientific literature, guidelines, consensus statements and expert opinions.

You can find **our** Medical, Dental and Pharmacy CPBs at **www.aetna.com/health-care-professionals/clinical-policy-bulletins.html**.

CPBs are not a description of cover. The conclusion that a particular **treatment**, service or cost is **medically necessary** does not confirm that this **treatment**, service or cost is covered under the **plan**. This Handbook, together with the **Benefits schedule** and **Certificate of insurance**, explains what is, and is not, covered under the **plan**. The **plan** may exclude coverage for **treatments**, services or costs that are determined as **medically necessary** within a CPB. If there is a discrepancy between a CPB and the **plan**, the terms of the **plan** will apply.

CPBs can be highly technical. **You** should talk about the information in them with **your medical professional** if **you** need to understand how they apply to **you**.

How to file a claim

For certain **treatments**, you will be required to contact Member Services to obtain **preauthorisation**.

Log in to your Health Hub

To use the online claims tool, **you** must be registered for the Health Hub. Register now, it only takes a minute. Visit **www.aetnainternational.com** , click 'Member' under the 'Secure Login' box. Choose the login/register button and follow the prompts. Once logged in choose 'Claims Centre' and 'Submit a claim'.

Fill out your claim form

Complete all sections of the claim form in full for each treated condition, including all hospitalisation claims.

Include all necessary documentation

Upload the following when prompted to your claim form (as appropriate):

- All paid receipts (or other proof of payment). **We** accept soft copies of original receipts to start the claim process and to facilitate the assessment of your claim; however, you should keep your original receipts on file in case they are needed for verification purposes.
- All supporting documents relating to the claim for all **treatments** referred to in the claim, including the diagnosis.
- Any laboratory test results and/or X-rays relating to the claim.
- A referral letter from **your specialist** (if the claim includes charges for diagnostic tests).
- A copy of the referral letter from **your medical practitioner** (if **treatment** was provided by a registered physiotherapist, chiropractor, osteopath, homeopath, podiatrist or acupuncturist).

Submit your claim

Submit your claim online:

After **you** submit **your** completed claim form, **you** will receive a notification by e-mail to confirm that it has been submitted successfully. This email contains **your** web reference tracking number. **You** can use that web reference tracking number to check the status of **your** claim and Explanation of Benefits (EOB) by visiting your Aetna Heatlh Hub at **www.aetnainternational.com** and clicking "Search claims" under the "Claims Centre" section.

Email submission: **CognizantService@aetna.com**

Postal submission:

Aetna Insurance Company Limited (Singapore Branch)
80 Robinson Road
#23-02/03
Singapore 068898

For claim related queries please contact our 24 hour Member Services helpline:

Toll-free from Singapore: **1800-622-7211**

Toll-free from other countries using AT&T access codes*:
+1 855 294-4463

Plan terms, conditions and exclusions

Plan terms

This **plan** is governed by the **plan** terms shown below.

Claims will only be paid in line with the **plan** terms that apply.

Altered and amended documents

P1 **We** reserve the right to reject or disregard any invoice, Claim form, medical report or other document that has been altered or amended.

Replacing and reissuing plan documents

P2 **We** can charge **you** an administration fee to replace or reissue any **plan documentation** or **Member ID Card**.

Waiver

P3 If **we** deviate from specific terms of the **plan** at any time, it will not constitute a waiver of **our** right to apply or insist upon compliance with those specific terms at any other time. This applies if the circumstances are the same or different. This includes, but is not limited to, the payment of premiums or **benefits**.

Plan governance and language

P4 The **plan documentation** and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) are governed by and shall be construed in accordance with the laws of Singapore. The courts of Singapore shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with the **plan documentation** or its subject matter or formation (including non-contractual disputes and claims).

P5 If **we** issue translated versions of any of **our** documents, these are for information only. In the case of any dispute or discrepancy of wording or interpretation, the English version will apply.

Third party negotiations

P6 **We** must be told about any negotiations or settlement discussions that **you** enter into, or are entered into on **your** behalf, with any other party about any action which leads to a claim under a **plan**. A settlement must not be agreed to with any party before **we** give **our** written agreement.

Hospital accommodation

P7 **Hospital** accommodation will be paid up to the cost of a standard single room with a private bathroom. This will include **your hospital** meals.

Medical examinations

P8 **We** have the right to instruct a **specialist** of **our** choice to examine **you** as often as **we** feel is necessary to support a claim. **We** also have the right to ask for further tests and or evaluation where **we** have decided that a **medical condition you** have claimed for may be directly or indirectly related to an excluded **medical condition**.

Lifetime limits

P9 If **you** move to a **plan** where a **lifetime limit** applies to a **benefit**, any amount previously paid under the same or equivalent **benefit** on any one or more other **plans** will be deducted from the current **lifetime limit** on the **benefit**. This applies:

- regardless of any previous **benefit** limit, and
- whether or not there has been a break in **your** cover.

Citizens of the United States of America

P10 If **you** are a citizen of the United States (US), **your area of cover** is Area 1 and, **you** will spend more than 180 days in the US during the annual policy year, we reserve the right to immediately cancel your cover. In this circumstance, you be required to buy an ACA compliant plan or face US tax penalties.

Rights of action against us

P11 If **you** want to take legal action against **us** in respect of a **plan**, **you** must do so within three years from the date the relevant event took place, subject to the applicable laws.

Subrogation

P12 If **you**

(i) receive, or

(ii) are entitled to receive,

any payment from any other party or from any other insurance cover in respect of an injury, illness or **medical condition**, **we** have the right:

- In the case of (i), to recover from **you** all amounts **we** have paid and may pay to **you**, or on **your** behalf under this **plan** as a result of the same such injury, illness or **medical condition**, up to and including the full amount received by **you** from such other party or other insurer
- In the case of (ii), to proceed against such other party or other insurer on **your** behalf and in **your** name by way of subrogation

You shall fully cooperate with **us** if **we** exercise **our** right of subrogation pursuant to the above.

You shall notify **us** immediately if **you**:

- give notice to any party of **your** intention to pursue or investigate, or
- pursue or investigate,

a claim to recover damages in respect of any injury, illness or **medical condition** sustained by **you** as a result of such other party's action or omission. On receipt of any such notice, **we** may elect in **our** sole discretion to exercise **our** right of subrogation pursuant to the above.

Other than with **our** prior written consent, **you** shall not:

- admit liability or fault; or
- agree to a settlement with any party in relation to any dispute relating to the above or the **plan**.

We will have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Contribution

P13 If any other insurance covers a valid claim under the **plan**, including any reciprocal health insurance arrangements, **we** shall deduct any payments received or to be received by **you** from such other insurer(s) for such claim from any amount payable to **you** by **us** under the **plan**, after:

- **you** have paid any **deductibles** applicable on such other insurance, and
- **you** have paid any **deductibles** on the **plan**.

Conditions

This **plan** is governed by the conditions shown below.

Claims will only be paid if **you** meet all of the conditions that apply.

Material facts

C1 The **plan administrator** must tell **us** all **material facts** before **we** accept an application, make changes to a **plan** or renew a **plan**. The **plan administrator** must check that any **material facts** are correct. **You** must check that any **material facts** about **you** are correct. If there is any doubt about whether a fact is material, for **your** own protection, the **plan administrator** should tell **us**. Where applicable the 24-month **moratorium** will still apply even if the **plan administrator** tells **us** about any **pre-existing medical conditions you** may have.

If **we** find out that the **plan administrator** has not told **us** about all **material facts we** can cancel the **plan** or apply different terms to the **plan**.

C2 The **plan administrator** must tell **us** immediately in writing about any change that affects information given in connection with the application for a **plan**, including information about **you**.

After **we** have been told about a change:

- **We** have the right to reassess **your** cover if it is a change to important information about **you**. **We** may apply new terms to **you**, or cancel **your** cover
- **We** have the right to reassess the **plan** if the change to important information is about the **plan sponsor** or affects all or part of the **plan**. **We** may apply new terms to the **plan**, or cancel the **plan**

If there is a change in risk that the **plan administrator** has not told **us** about, **your** cover may be cancelled, the **plan** may be cancelled, or any related claim may be reduced or rejected.

Preauthorisation and timely claim filing

C3 If a **benefit** needs **preauthorisation** as shown on **your Benefits schedule**, **you** or **your** personal representative must request **preauthorisation** before **treatment** or services are received or costs are incurred. Once **you** or **your** personal representative have received **our** approval, **we** will settle all covered costs directly with the providers. If **you** or **your** personal representative do not receive **our** approval before costs are incurred, **we** will only approve the costs **we** would have paid if **we** had been involved and given **our** approval.

C4 **You** or **your** personal representative should tell **us** about a claim no later than:

- 60 days after the date of **treatment** or services received, if it relates to **your** medical **plan**

If a claim is not received within the period shown, **we** reserve the right to reject such claim subject to the applicable laws.

Treatment provision and referral

C5 All **treatment** must be given with the aim to cure or substantially relieve **medical conditions**.

C6 **Treatment** must be given by **medical practitioners**, **specialists**, **nurses** or **therapists**. All psychiatric **treatment** and psychotherapy must be given by **medical practitioners**, psychiatrists or qualified and registered psychotherapists or psychoanalysts.

C7 If **your medical practitioner** or **specialist** refers **you** for further **diagnostic tests and procedures** or **treatment**, **we** may not pay **your** claim if **you** do not undergo the **diagnostic tests and procedures**, or start **treatment**, within 90 days of the referral date.

C8 Physiotherapy, podiatry, osteopathic and chiropractic **treatment** must be referred by a **medical practitioner** or **specialist**.

Innocent bystanders

C9 Where a **benefit** is available on **your plan**, **we** will cover costs arising from or connected with:

- **conflict or civil unrest** if, in **our** reasonable opinion:
  - **you** are not actively participating,
  - **you** are not a member of any armed force or security service, including personal protection,
  - **you** have not knowingly entered or remained in a location where there is **conflict or civil unrest**, and
  - **you** have not intentionally put **yourself** at risk of injury.
- a natural disaster if, in **our** reasonable opinion:
  - **you** have not knowingly entered or remained in a location where there is a natural disaster, and
  - **you** have not intentionally put **yourself** at risk of injury.

- contamination or injury from any biological, chemical or nuclear materials, including combustion of nuclear fuel if, in **our** reasonable opinion:

  - **you** have not knowingly entered or remained in a location where there is contamination,

  - **you** are not a member of a biological, chemical or nuclear contamination cleaning crew of any kind, and

  - **you** do not intentionally put **yourself** at risk of contamination or injury.

Reasonable costs

C10 Only reasonable costs will be paid for claims. Reasonable costs are the average cost of **treatment**, expertise or services given by similar types of provider:

- within the same country or geographical region, and
- based on **our** knowledge and experience.

C11 If a **visiting doctor** instead of an **in-house doctor** treats **you**, in a **hospital**, clinic or any other facility where direct billing or cashless arrangements are in place, only reasonable costs will be paid. **You** will have to pay the difference if the **visiting doctor's** costs are not reasonable and not in line with the **in-house doctor's** costs.

Ineligible claims

C12 If **you** attend a **hospital**, clinic or any other facility where direct billing or cashless arrangements are in place, and **we** subsequently determine that **your** claim is an **ineligible** claim, **we** have the right to recover the full amount of the claim. Payment of any claim is not an indication of **our** acceptance of liability for the claim or confirmation that further costs for the same **medical condition** or any **related medical condition** will be met.

C13 If **we** receive new information that shows a claim **we** have already approved is **ineligible**, no costs will be paid. If any costs have already been paid, **we** will recover the costs and no further costs will be paid. Any approval **we** have given during the **preauthorisation** process may also be withdrawn. After **we** have given notice that **you** must repay any costs, this must be done within 14 days, failing which, **we** reserve the right to cancel the **plan**, subject to applicable laws.

C14 If **you** would like **us** to re-assess a claim **we** have rejected under a **plan** for any reason, **you** will have to prove that the claim is covered under the **plan**.

Exclusions

The **plan** does not cover claims for, arising from or connected with the following exclusions unless shown on **your Benefits schedule**, or agreed by **us** in writing.

A **medical condition** or symptom that **you** were aware of before **your start date** unless **we** were given all the information **we** asked for and **we** have not specifically excluded the **medical condition** or symptom as shown on **your Certificate of insurance**.

Plan and benefit availability and limitations

E1 Costs incurred:

- That exceed a limit shown on **your Benefits schedule**
- If **you** have not completed the waiting period shown on **your Benefits schedule**
- If these are less than the value of any **deductible** that applies to **your plan**
- If no relevant **benefit** is included on **your plan**
- For a **benefit** not covered on **your plan**, even if cover was included in any previous **plan year**
- That may be associated with a claim, but are not covered under **your plan**. For example, loss of earnings as a result of a **medical condition**
- Outside **your area of cover**

E2 Costs incurred for, or in relation to, any portion of **treatment** or services received before **your start date** or after **your end date**.

E3 Medical evacuations if a local situation makes it impossible, dangerous or not practical to enter a specific location or country.

False and fraudulent claims

E4 A false or fraudulent act **you** know about. If **we** have paid any part of the claim, **we** will recover the costs.

Treatment provision and referral

E5 **Treatment** that **we** determine on **general advice** is unproven, experimental or investigational.

E6 Drugs or dressings that:

- are not recognised by the pharmaceutical regulator in the country where **treatment** is provided,
- are obtained without prescription, or
- are prescribed for a **medical condition** that is different to the one that is being claimed for.

E7 Dietary supplements, substances and personal products, including, but not limited to, vitamins, minerals, mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, children's food, baby supplies and infant formula given orally.

E8 Home visits by a **medical professional**, unless specifically agreed by **us** prior to consultation.

E9 **Treatment** in a spa, hydro spa, health farm or similar facility, and **treatment** given at a nursing home, similar establishment or **hospital**, where the facility has become **your** home or permanent abode or where admission is arranged partly or entirely for non-medical reasons.

E10 **Treatment** given, or referrals made by, a **medical professional** or **dental** practitioner who is **your** spouse, **partner**, child, parent or sibling, and self-prescribed **treatment** or self-referral if **you** are a **medical professional** or **dental** practitioner.

E11 Health education programmes and services, including, but not limited to, family planning, antenatal classes and parenting classes.

Administrative costs, fees and charges

E12 Costs of:

- Completing Claim forms
- Completing or obtaining any other documents
- **Hospital** administration fees
- Any registration fees

E13 Charges incurred for the overdue payment of any invoice.

Cosmetic

E14 Cosmetic **treatment**.

Weight management

E15 Any **treatment** for weight loss or weight problems, including, but not limited to, bariatric procedures, diet pills or supplements, health club memberships, diet programmes and residential eating disorder programmes.

Reproduction and newborns

E16 Costs of:

- Contraception or sterilisation
- **Treatment** for sexual problems, including impotence, whatever the cause
- Fertility or infertility tests or **treatment**
- Assisted reproduction
- Surrogacy

E17 Termination of a pregnancy which is not due to a medical necessity.

E18 Any **inpatient treatment** needed for an **acute medical condition** that begins before an insured **member** is eight days old if the mother's pregnancy was the result of assisted conception.

Sleep

E19 Not applicable.

Sight, hearing and dental

E20 Myopia, hypermetropia, astigmatism, natural or non-medical degenerative sight or hearing disorders, aids to help with sight or hearing, contact lens solutions, eye drops, sunglasses and prescription sunglasses.

E21 **Orthodontic treatment** and dental implants.

Brain and learning disorders, and speech and voice problems

E22 Developmental disorders of the brain, learning disorders, learning difficulties, speech problems and voice problems.

Harvesting, storage and organ transplants

E23 The harvesting or storage of umbilical cord blood stem cells, sperm, mature oocytes and embryos.

E24 Costs of:

- locating a replacement organ,
- transporting an organ, and
- any associated administration.

Addictions and abuse

E25 **Treatment** for alcohol, drug or substance abuse or any kind of addictive condition, and any injury or illness arising directly or indirectly from such abuse or addiction. Drug abuse is the use of any drug:

- in a manner or in quantities other than as directed or prescribed on medical authority, or
- for any reason other than that for which it was originally prescribed.

Gender reassignment

E26 **Treatment** directly or indirectly associated with gender reassignment.

Journeys and transportation

E27 Any journey made specifically for the purpose of receiving **treatment**, unless **you** have requested **preauthorisation** and **we** have given **our** approval.

E28 Non-emergency transportation.

Acting against medical advice

E29 Any journey, activity, action or pursuit carried out against the **advice** of a **medical professional**.

Professional sports and hazardous activities

E30 Playing professional sports, taking part in motor sports of any kind, using a weapon or firearm for any purpose, and the following hazardous activities:

- Mountaineering, potholing, spelunking and caving
- High-altitude trekking over 2,500 m
- Winter sports carried out off-piste
- Arctic or Antarctic expeditions

Self-inflicted medical conditions

E31 Suicide, attempted suicide or any deliberate, self-inflicted **medical condition**.

Illegal activities

E32 **You** acting illegally, or committing or helping to commit a criminal offence.

E33 Any **inpatient**, **daycare** or **outpatient treatment** in a **hospital**, whether planned or not:

- when received before **your start date,** if the **treatment** is still ongoing at **your start date**, or
- that **you** were aware of at **your start date**,

unless **you** or the **plan sponsor** told **us** about it before **your start date** and cover has been agreed by **us**.

E34 **Treatment** to change the refraction of one or both eyes, including refractive keratotomy (RK) and photorefractive keratectomy (PRK), unless **we** agree in writing.

Data Protection

The words 'Aetna' and 'other Aetna entities' mean Aetna Global Benefits (UK) Limited and include any other Aetna International Inc. group company as the context requires.

We are committed to protecting your personal data and privacy. Any personal information that we collect will be kept confidential and will be processed in accordance with the Personal Data Protection Act and medical confidentiality guidelines, other related legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

We may, in carrying out your instructions, processing and administering claims, transfer your personal data to other Aetna entities and/or third parties acting on our behalf. However, wherever it is held and processed, your personal data will be protected by a strict code of security which we and any third parties working on our behalf are subject to. Your personal data will only be used in accordance with our instructions.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to other Aetna entities or agents or others as permitted by law so that they may do the same. They may pass information held by them about you to us so that we may do the same. We may also disclose your information if we are required to do so by law enforcement or other legal agencies, governmental or judicial bodies, or to our regulators under proper authority.

In order to assess the terms of your insurance cover, including specific medical exclusions, or to administer claims, we may collect medical information. Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

We will not disclose your medical information to any other individual without your explicit consent. If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

We may, from time to time, provide you with marketing information about Aetna, our products and services and those of any associated companies which may be of interest to you. You will be given an opportunity to tell us if you do not wish to receive such information.

To help us make sure that your personal information remains accurate and up-to-date, please inform us of any changes.

If you have any queries regarding privacy issues, then please write to:

The Data Protection Officer
Aetna Insurance Company Limited (Singapore Branch)
80 Robinson Road
#23-02/03
Singapore 068898.

Complaints

We strive to give you a first-class service. However, if there is an occasion when you feel we have not done this we want to know.

Please contact us at:
The Complaints Team
Aetna Insurance Company Limited (Singapore Branch)
80 Robinson Road
#23-02/03
Singapore 068898

Telephone: **+65-6593-8500**

E-mail: **AetnaInternationalComplaints&Appeals@aetna.com**

When you contact us it will help if you give us your plan number and claim number, if this applies. Please also provide as much information as you can about your complaint, as well as your full contact details.

We will deal with your complaint fairly, promptly and in accordance with relevant regulation.

We will acknowledge your complaint within three business days. If we need additional information, we will contact you to request this. Should your complaint take longer to resolve, we will keep you updated on its progress and contact you within 15 business days of our last communication with you until a resolution is provided to your complaint.

If you are not satisfied with the outcome of your complaint, you can write to the Chief Executive, Aetna Insurance Company Limited (Singapore Branch), at the address provided above.

Your appeal will be considered and you will be provided with a final response within 14 days of receipt.

If following receipt of our Chief Executive's response you are still dissatisfied, you may be able to refer it to the Financial Industry Disputes Resolution Centre Ltd (FIDReC), FIDReC is an independent body that mediates in disputes between financial firms and consumers.

They can be contacted as follows:
Financial Industry Disputes Resolution Centre Ltd (FIDReC)
112 Robinson Road
#08-01 (Singapore) 068902.

Telephone: **6327 8878**

Fax: **6327 8488**

Email: **info@fidrec.com.sg**

Website: **www.fidrec.com.sg**

We are a member of the General Insurance Association of Singapore (GIA) and subscribe to the GIA's General Insurance Code of Practice, which can be viewed at **www.gia.org.sg/pdfs/code_of_practice.pdf**

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 or SDIC websites (www.gia.org.sg or www.sdic.org.sg).

Help us manage fraud

Fraud, let's beat it together

Fraud is a crime and healthcare fraud increases premiums for our customers. This is why, with your help, we will do our utmost to detect and eliminate it.

Fraud is the dishonest intent to get financial gain from, or cause a financial loss to a person or party through false representation, failing to disclose information or abuse of position.

There are many examples of fraud, some of these are:

- Giving false or misleading information in order to obtain insurance or a reduction in premium
- Claiming for treatments or services not received
- Altering or amending invoices or any other documents
- Deliberately failing to disclose previous medical history when required
- Giving a false diagnosis
- Claiming from more than one insurer for the same treatment or service
- Using somebody else's insurance to obtain treatments or services

We are committed to protecting you against fraud and we also have statutory responsibilities to prevent our products from being used as a vehicle for financial crime.

Maladministration, including innocent and careless overcharging for treatments and services, also raises the cost of medical insurance.

Some examples of maladministration include:

- Billing twice for the same service
- Incorrect billing for treatments or services
- Providing unnecessary treatments or services

How you can help to protect yourself and keep premiums down

There are simple steps you can take to protect yourself. Some of these are:

- Compare invoices with your records. Check the dates are correct and the treatments or services were actually provided to you
- Ask questions if there is anything you are unsure of, do not understand, expect or recognise
- Keep in close contact with us if you have made a claim
- Let us know if you are concerned that your medical practitioner is providing treatment that is not necessary for you
- Carefully fill in any Claim forms. Ask us if there is anything you are unsure of or do not understand
- Look after your insurance details and documentation
- Make sure you understand any documentation before you sign it
- Keep copies of any documentation and correspondence
- Report suspected fraud to us

We work closely with others to prevent fraud

We are committed to protecting you against fraud and we also have statutory responsibilities to prevent our products from being used as a vehicle for financial crime. In addition to our strict controls to deter, prevent, detect and investigate fraud, we also work with other insurance providers to give you the best service we can. Other providers we work with are:

- International Insurance bodies
- International Police and Investigative agencies
- Government departments

If you suspect fraud

Please contact us at:

Fraud and Investigation e-mail: **fraudgovernance@aetna.com**

Fraud and Investigation Confidential telephone line: **+44-(0)1252-896-383**

Definitions

Accident – any involuntary or unexpected event resulting in a **bodily injury**.

Act of terrorism – an act by any person, group or groups of people, including, but not limited to, the use or threat of force or violence, whether acting alone, on behalf of, or in conjunction with, any organisation or government. This includes, but is not limited to, acts intended to influence any government or cause fear to members of the public, whatever the reason.

Acute – a **medical condition** that is brief, has a definite end point, and, in **our** reasonable opinion, based on **advice** or **general advice** can be cured by **treatment**.

Acute episode – an unexpected, adverse, change to the usual state of a **member's chronic medical condition**, which responds to **treatment** that aims to return them to their state of health before the event occurred.

Advice – any consultation or information given by a **medical professional**.

Appliances – prostheses surgically implanted to form permanent parts of the body.

Area of cover – the geographic area of the world in which a **member's plan** applies. This is shown on their **Certificate of insurance**.

Benefit – cover provided by a **plan**, and any extensions or restrictions shown in the Handbook, **Certificate of insurance** or **Benefits schedule**.

Benefits schedule – the document that details the **benefits** available under a **plan**.

Bodily injury – any physical harm to a **member**.

Certificate of insurance – a document that provides **plan** details, including dates of cover, **member** information and any special terms that may apply.

Chronic – a **medical condition** that has at least one of the following characteristics:

- Continues indefinitely and has no known cure
- Comes back or is likely to come back
- Is permanent
- Needs rehabilitation or special training for a **member** to cope with it
- Needs long-term monitoring, including consultations, checkups, examinations and tests

Claims procedures – the document that explains how to make a claim under a **plan**.

Close family member – a son, daughter, stepson, stepdaughter, legally adopted son, legally adopted daughter, spouse, **partner**, parent, step-parent, legally adoptive parent, parent-in-law, grandparent, grandchild, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law or legal guardian.

Coinsurance – a percentage of costs a **member** must pay towards a covered claim.

Conflict or civil unrest – any **act of terrorism**, war, invasion, foreign enemy hostility (whether or not war is declared), mutiny, riot, strike, civil war, rebellion, revolution, insurrection or attempted overthrow of government, usurped power, martial law or state of siege.

Congenital abnormality – any genetic, physical, biochemical or metabolic defect, disease or malformation, which may be hereditary or due to an influence during gestation, and which may or may not be obvious at birth.

Country of nationality – any country for which a **member** holds a valid passport.

Country of residence – the country a **member** lives in for most of the time, usually for a period of at least six months during a **plan year**.

Critical – a **medical condition** that is, in **our** reasonable opinion, unstable and serious, where the outcome cannot be medically predicted, the prognosis is uncertain and the person may die.

Date of joining – the date when a **member** first enrolled or re-enrolled if there is a break in their cover.

Daycare – where **treatment** is received at a **hospital** or daycare unit, medical supervision is needed for four or more hours for recovery and the **member** does not stay overnight.

Deductible – any **coinsurance**, **excess** or reasonable and customary deduction that applies to a **plan**.

Dental – that which affects the teeth and gums.

Dependant – a **main member's**:

- Spouse or **partner**
- Unmarried child, stepchild or legally adopted child under the age of 18
- Unmarried child, stepchild or legally adopted child aged 18 to 25 who is in continuous full-time education. **We** may need written proof from the educational facility where they are enrolled.

Diagnostic tests and procedures – any medically necessary test or examination to investigate the cause of a **member's** signs or symptoms.

Direct billing – where **we** settle costs of **outpatient treatment** or services directly with a provider in the **network**.

Eligible – the costs for **treatment** or services that qualify under the **plan**, as described in the **plan documentation**.

Emergency – a sudden, unexpected acute medical condition or an unexpected acute episode of a chronic medical condition that, in our reasonable opinion and based on advice if available, presents a clear and significant risk of death or imminent serious damage to bodily function.

End date – the last day a member has cover under a plan.

Excess – an amount a member must pay towards the cost of part, or all, of a covered claim or claims.

Foreseeable – a medical condition that, in our reasonable opinion, could be reasonably anticipated.

General advice – any medical opinion or medical recommendation from a relevant professional body in relation to a medical condition or treatment, which confirms, in our reasonable opinion, established medical practice or opinion.

Group formation application – the document entitled 'Aetna Summit Group plan application' which must be completed and signed by the plan sponsor to agree to the terms of the plan plus any supporting information given in connection with it.

Group member application – the document entitled 'Aetna Summit Group member application' which must be completed and signed by the member to agree to the terms of the plan plus any supporting information given in connection with it.

Home country – the country a member is from as given to us on their Application.

Hospital – an establishment that is licensed to provide inpatient, daycare and outpatient medical and surgical treatment in accordance with the laws of the country in which it is situated.

Ineligible – the costs for treatment or services that do not qualify under the plan, as described in the plan documentation.

In-house doctor – a doctor who is employed by the hospital, is considered a permanent member of staff and charges in line with hospital tariffs.

Inpatient – where treatment is received at a hospital and, based on advice, the member needs to stay in a bed for one or more nights.

Intrinsic value – the actual cash value of an item at the time of loss or damage, including appropriate deductions for wear and tear.

Lifetime limit – the total amount that will be paid for any eligible claim for costs incurred during any time a member is covered on any one or more plans with the same or equivalent benefit, even if there is a break in their cover. See plan term P9 for more information.

Main member – a member who is employed by the plan sponsor, or has an affiliation or similar legal relationship with them, which we agree meets the eligibility criteria.

Material fact – information which you have given us which is, in our reasonable opinion, likely to influence us in our assessment, acceptance or renewal of your membership of the plan, or in making any changes to the plan. This includes but is not limited to your responses to our questions about yourself, your lifestyle, your health or your medical conditions.

Medical condition – any signs or symptoms, injury, illness or disease.

Medical History Disregarded (MHD) – we will cover a member's pre-existing medical conditions, subject to the benefits, terms and conditions of the plan.

Medical necessity, medically necessary – treatment that is prescribed by a member's medical practitioner or attending specialist, is in line with general advice, and in our reasonable opinion, is appropriate for their medical condition.

Medical practitioner – a person who:

- has attained primary degrees in medicine or surgery by attending a medical school recognised by the World Health Organisation, and
- is licensed by the relevant authority to practice medicine in the country where the treatment is given.

Medical professional – any medical practitioner, specialist, nurse, therapist, psychiatrist, or qualified and registered psychotherapist or psychoanalyst.

Member – a person we have agreed to cover under a plan as named on the Certificate of insurance.

Member ID Card – a card we issue for each member, which provides basic plan details and contact information.

Natural teeth – any teeth that are original, not artificial implants or replacements.

Network – all of the providers with whom there are healthcare arrangements for our members.

Nurse – a person who is qualified in nursing, currently practising and on the professional register of nursing in the country where the treatment is given.

Orthodontic – that which affects the structure, function, development or appearance of the teeth, upper or lower jaw or the oral cavity.

Outpatient – where treatment is received at a medical facility that is recognised by the relevant authority in the country where the treatment is given, and the member is not admitted for inpatient or daycare treatment.

Palliative treatment – any medical or surgical services aimed to relieve the symptoms rather than to cure, stop, reverse, or delay the progression of the medical condition causing them.

Partner – a person who is in an established personal relationship with the **main member**, but is not married to the **main member**.

Personal effects – personal belongings, including clothing worn and baggage owned by a **member**, that they take with them on their **trip**.

Plan – **our** contract of insurance (made up of all of the documents which form the **plan documentation**) with the **plan sponsor**, which takes effect on the **plan start date**.

Plan administrator – the person who acts as the **plan** coordinator on behalf of the **plan sponsor**, as chosen by the **plan sponsor**.

Plan documentation – Group formation application(s), Certificates of insurance, Plan sponsor guide(s), Handbook(s), **Benefits schedule(s),** final membership census, **Group member applications** (if these apply), Group member declarations (if these apply) and **Claims procedures**.

Plan level – the **plan sponsor's** choice of **plan** or Aetna Personal Accident **plan** from the range available.

Plan renewal date – the date when a new **plan year** is due to begin, as shown on a **Certificate of insurance**.

Plan sponsor – the entity that purchases a plan for eligible **main members**, and their eligible **dependants** where agreed.

Plan start date – the first day of each **plan year**, as shown on a **Certificate of insurance**.

Plan year – the period of cover from the **plan start date** to the day before the **plan renewal date**, as shown on a **Certificate of insurance**. This is usually a period of 12 months.

Preauthorisation – **our** assessment of **treatment**, services or costs before they are received or incurred.

Preauthorised – any **treatment**, services or costs that **we** approve as a result of **preauthorisation**.

Pre-existing – any **medical condition** or **related medical condition** that, in **our** reasonable opinion, has any one or more of the following characteristics:

- Was foreseeable
- Clearly showed itself
- A **member** had signs or symptoms of
- A **member** asked for **advice** about
- A **member** received **treatment** for
- To the best of a **member's** knowledge, they were aware they had

Preventative services – medical services received when no signs or symptoms are present, and they are not received in relation to a diagnosed **medical condition**.

Public transport – any paid and licensed type of transport.

Related medical condition – any injury, illness or disease that, based on **advice** or **general advice**, **we** determine is the result of any one or more other **medical conditions**.

Routine health check – diagnostic tests or procedures where no signs or symptoms are present, and they are not received in relation to a diagnosed **medical condition**. This includes any cancer screening a **member** receives after they have been in remission for more than five years.

Singapore government restructured hospital – a **hospital** or specialist centre that receives government funding to provide lower cost medical services.

Specialist – a **medical practitioner** who, in the country where the **treatment** is given:

- has a recognised certificate of higher specialist training in the relevant field of medicine, and
- has a consultant appointment or equivalent.

Start date – the first day a **member** has cover under a **plan** during a **plan year**, as shown on their **Certificate of insurance**.

Terminal – the end stages of a **medical condition** where life expectancy is considered to be days or weeks and only **palliative treatment** and care is given.

Therapist – a physiotherapist, podiatrist, osteopath, chiropractor, Chinese herbalist, ayurvedic practitioner, acupuncturist or homeopath, who is qualified and licensed in the country where the **treatment** is given.

Treatment – any medical or surgical service, including **diagnostic tests and procedures**, needed to diagnose, relieve or cure a **medical condition**.

Visiting doctor – a **medical practitioner** or **specialist** who is not employed by the **hospital**, but has a contract to use the **hospital** facilities and may have different charges to the **hospital** tariffs.

We/our/us – Aetna Insurance Company Limited (Singapore Branch).

You/your/yourself – **you** as a **member**.

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All Singapore Citizens and Permanent Residents will be covered by MediShield Life from 01 Nov 2015. If you choose not to accept this medical expense policy, you will continue to be insured under MediShield Life for life, without any exclusion.

This product is not a Medisave-approved product and the premium for this policy is not payable using Medisave.

This is a short-term A&H product and is not guaranteed renewable. The insurer has unilateral rights to terminate this policy at each policy renewal date. Also, if you have existing medical conditions, you may:
• Lose coverage for your existing medical conditions; or
• Pay additional premiums to retain or increase coverage for your existing medical conditions under this new policy.

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

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