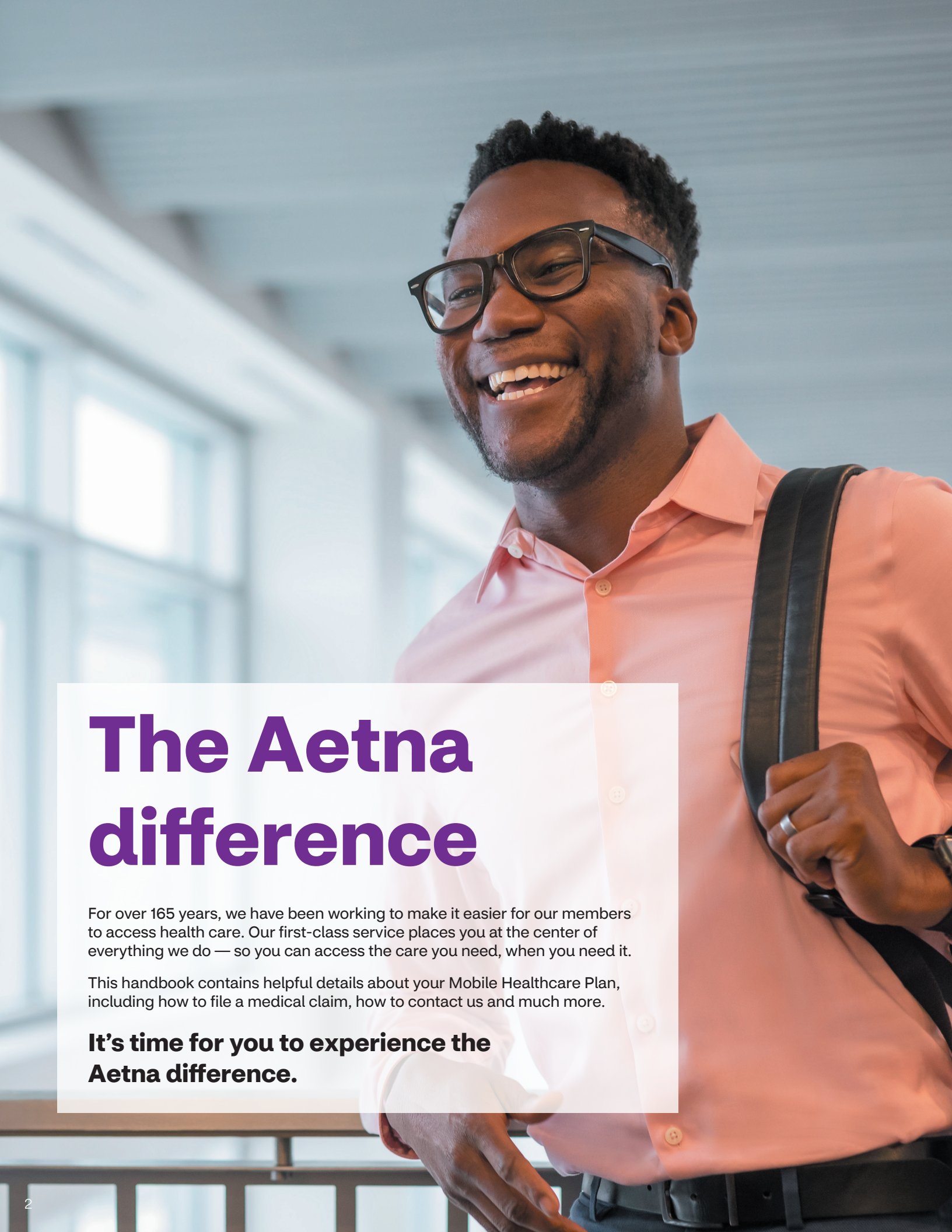
Aetna Mobile Healthcare Plan

Basic/Basic Plus
This product is only available on a renewal basis and is no longer available for sale

AetnaInternational.com

46.02.586.1-AM C (7/21)

aetna™



The Aetna difference

For over 165 years, we have been working to make it easier for our members to access health care. Our first-class service places you at the center of everything we do — so you can access the care you need, when you need it.

This handbook contains helpful details about your Mobile Healthcare Plan, including how to file a medical claim, how to contact us and much more.

It’s time for you to experience the Aetna difference.

Experience the Aetna difference

We're an experienced world leader committed to building healthier communities. As part of Aetna — a Top Fortune 500® company with more than 165 years of experience and 46 million members — we leverage our deep market knowledge to deliver comprehensive health care solutions to you. You can count on us for:

- World-class private medical insurance and wellness solutions
- Innovative health care solutions
- Certainty from working with a financially strong organization

We pride ourselves on putting you at the center of everything we do through our best-in-class, concierge level service — so you get the care you need, exactly when you need it.

This handbook contains helpful details about your plan, including how to file a medical claim, how to contact us and so much more.

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

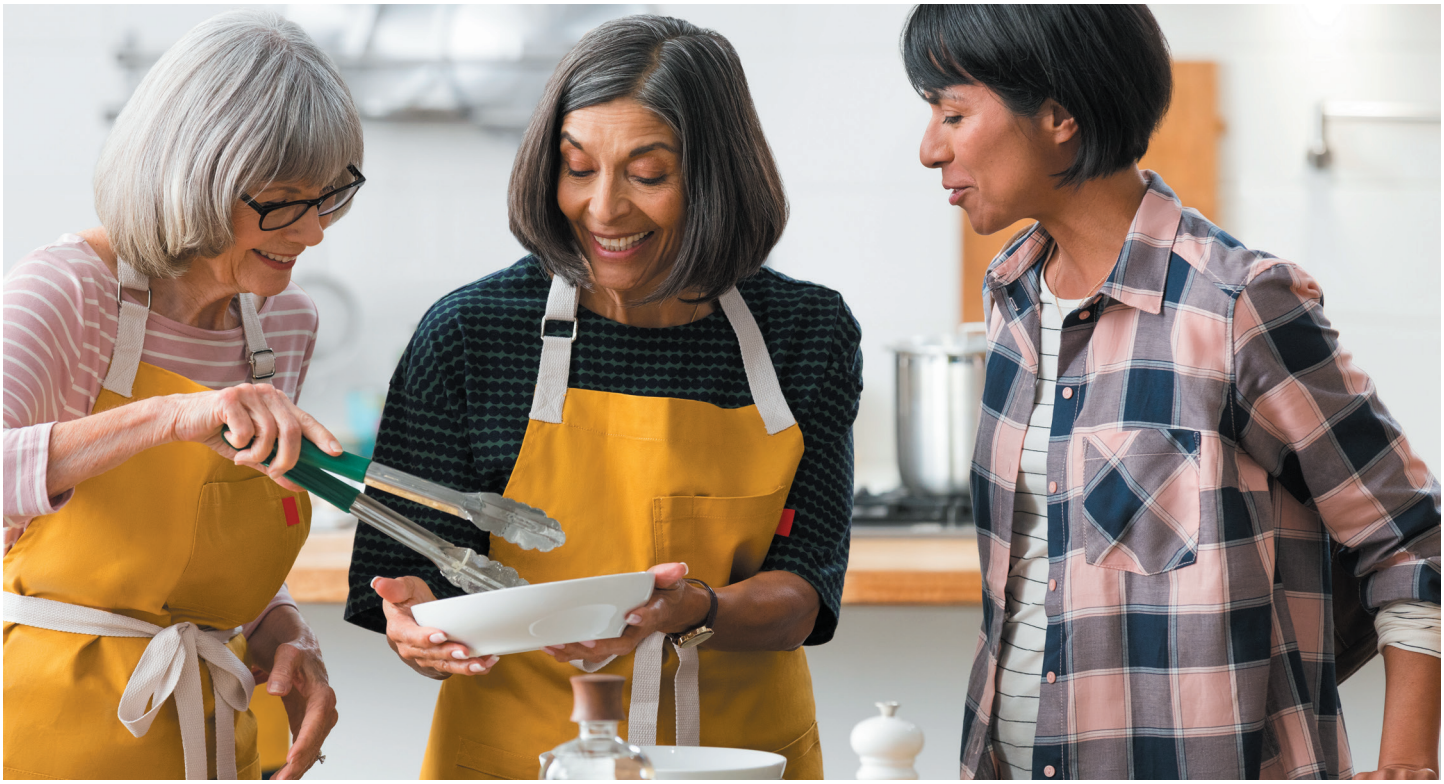
What you should do right now

Get your member ID card

It's your all-access pass to better care

Your Aetna Member ID Card is your key to quality health care. We recommend keeping your Aetna Member ID Card with you at all times, so you have it when you need it. Your card has:

- Your Aetna Member ID number — use it when seeking care and registering online
- Member Service Center phone number — if you have questions
- Emergency Services phone number — for easy access in case of a medical emergency



Get connected

Sign up for Health Hub

Health Hub is your personalized, secure member website that's fast and easy to use on any device.

With Health Hub you can: find care outside of the United States, access your plan documents and take advantage of industry-leading tools to help you manage your benefits. It's optimized to work equally well on any device, including your mobile phone or tablet. Using Health Hub, you can:

- Find nearby doctors and hospitals
- Access your health care plan documents
- Submit claims faster and easier
- Access Aetna Well-being, our comprehensive menu of well-being resources
- Take our health assessment to understand your current state of health

It's easy to register

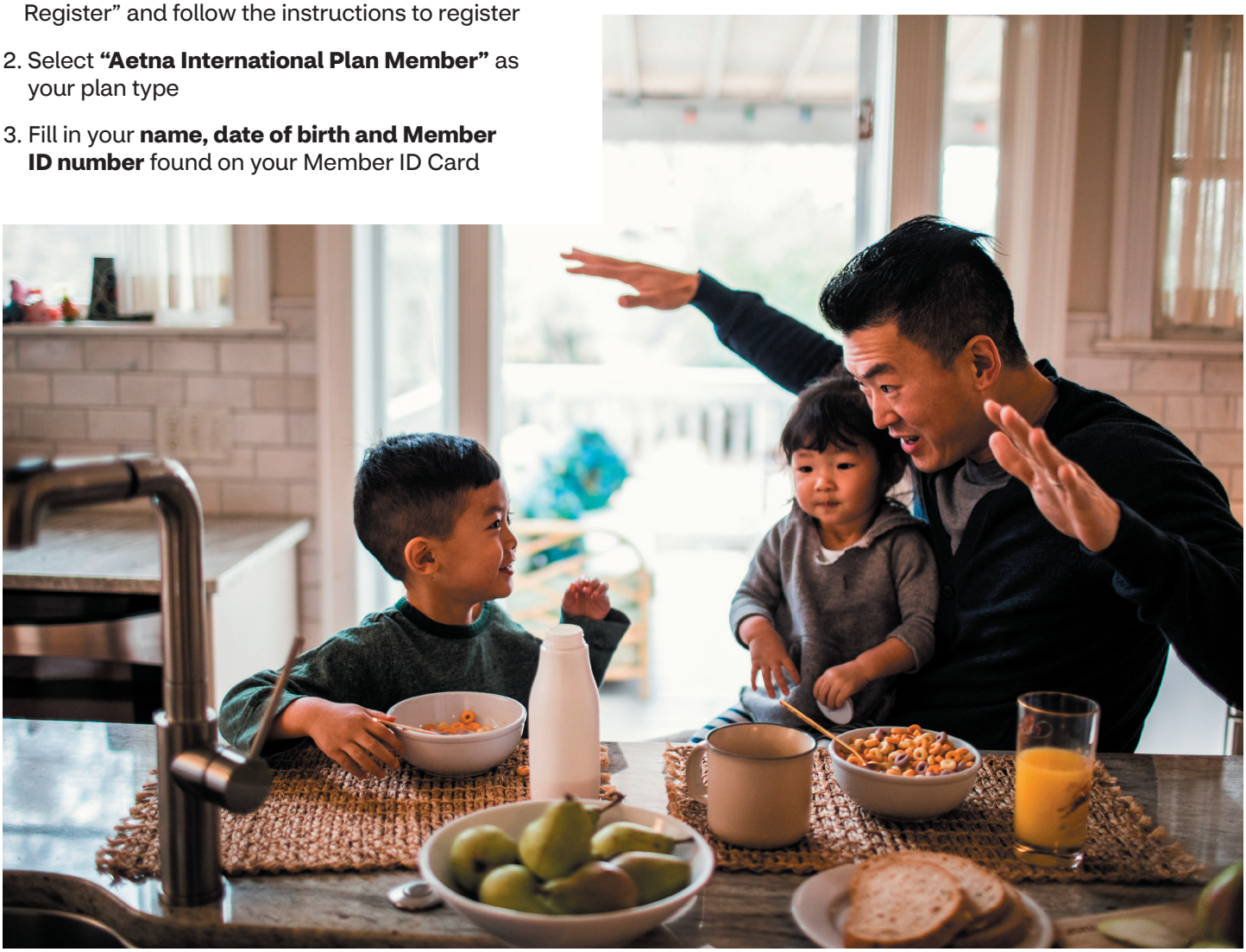
1. Go to **AetnaInternational.com**, click "Login In / Register" and follow the instructions to register
2. Select **"Aetna International Plan Member"** as your plan type
3. Fill in your **name, date of birth and Member ID number** found on your Member ID Card

International Mobile Assistant app

Life takes you places. And no matter where you are in the world, it's important to have easy access to the information and tools you need to make good health care decisions. Our free mobile app puts the most important and useful features of your secure member website right on your smartphone.

- Use the International Mobile Assistant app when you're out of the United States to:
- Submit your claims
- Search for doctors and hospitals outside the United States
- Find forms, health care resources and more

It's free to download. Just search "Aetna International" in the App Store or Google Play store. If you haven't already registered for Health Hub, you'll need to do that before you can use the International Mobile Assistant app.



Aetna Well-being

Staying on top of the demands of work, life and personal issues can be challenging.

That's why we're committed to providing you with access to Aetna Well-being — industry-leading self-help tools and professional support to help you reach your best health. You have access to self-help tools and professional support to fit your needs.

You'll find Aetna Well-being on Health Hub, arranged in four easy-to-navigate categories:

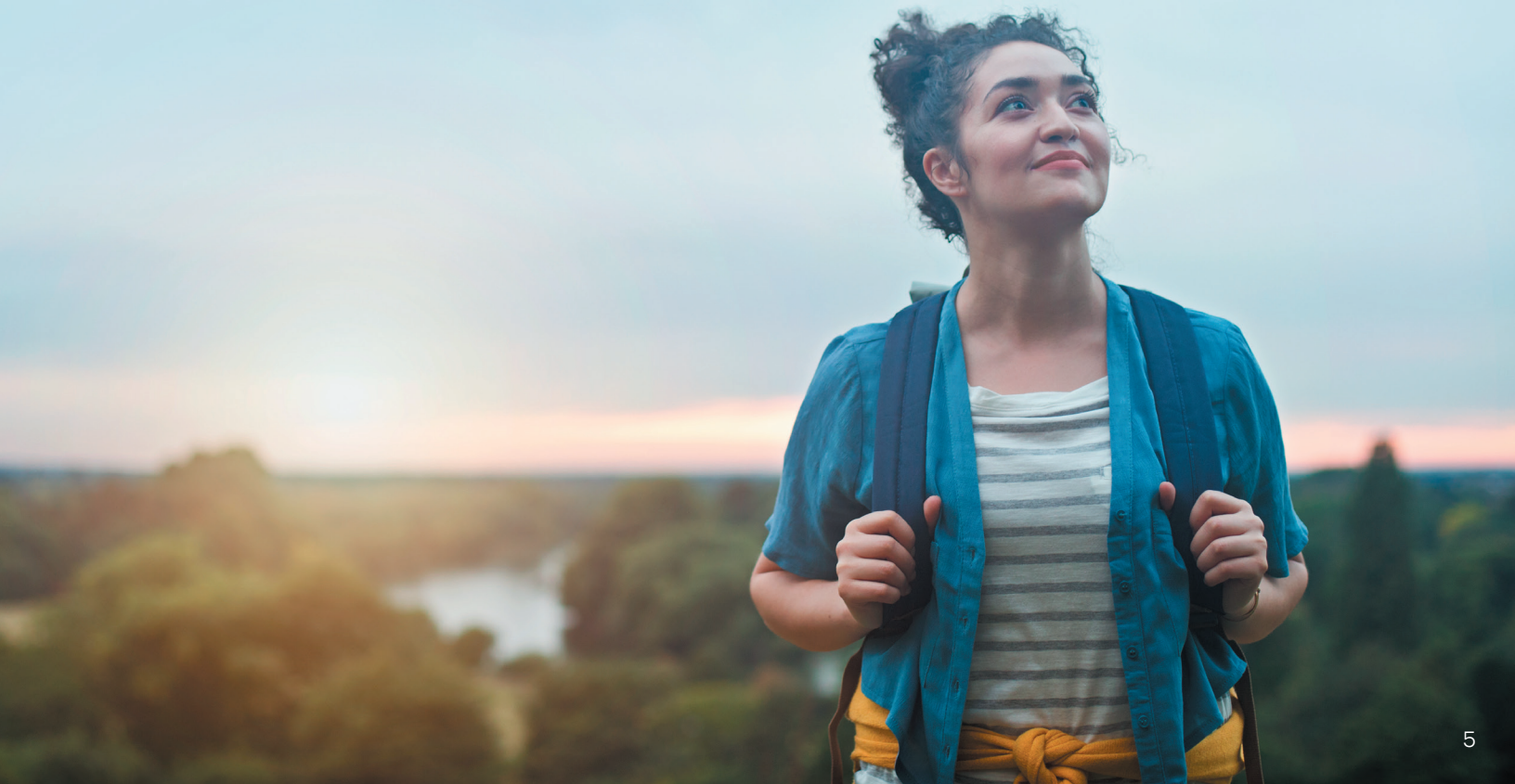
Mind — Support for mental health and emotional well-being

Body — Resources to help maintain physical health

Living and working abroad — Help making informed decisions while adjusting to a new working environment and living away from home

Member offers — Specially selected offers on great health and wellness apps and services

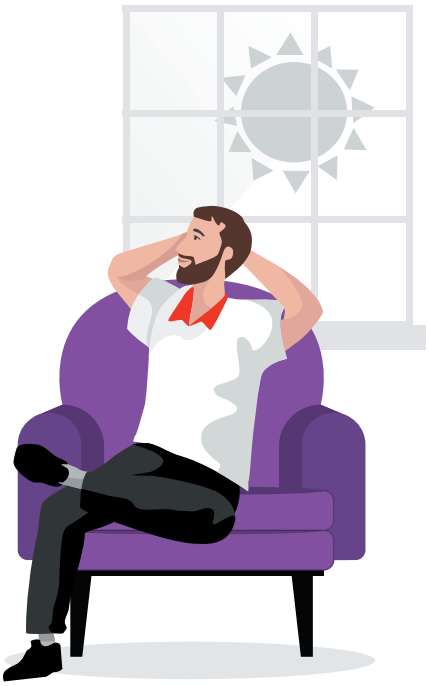
As the world continues to grow more and more complex, the need for mental and emotional health services has never been greater. The services we provide through Aetna Mind have the potential to help reduce the risk of chronic diseases related to stress, anxiety and substance abuse, while significantly improving the lives of those who may be struggling with mental and emotional health challenges. So, why not explore Aetna Mind today!



Get a head start on happy

No matter how you're feeling, Aetna Mind has the right support

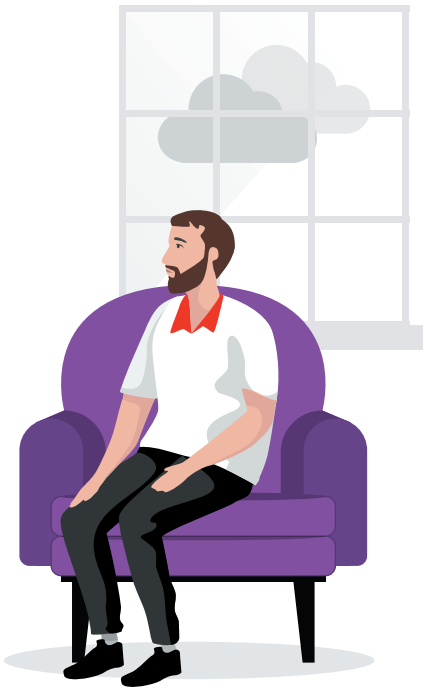
We want to support you on your journey to better mental and emotional health. You tell us how you're feeling, and our Aetna Mind Resource Selection Tool matches you up with the right kind of support from our industry leading Aetna Mind resources.



Healthy and thriving

Discovery and growth

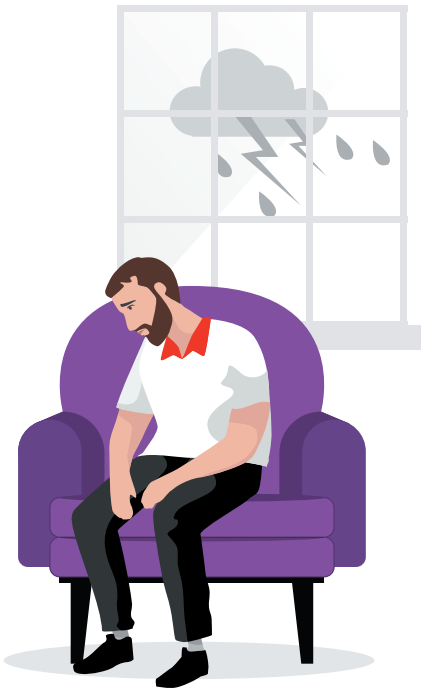
Maximize your mental health and achieve your best self with our wide range of **self-help resources**.



Surviving but struggling

Direction and assistance

Restore yourself with a combination of **self-help resources** and **professional services** to fit your needs



In crisis and unwell

Treatment and support

Take advantage of our full-service mental healthcare by selecting the best provider for you in our **professional services**

Aetna Mind

Resource Selection Tool

It's easy to get started

To use our Aetna Mind Resource Selection Tool, **log in to Health Hub** now! If you need help logging in, no problem! Just call the number on your Member ID card and we'll be more than happy to help you.

Get ready for your next doctor's visit

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

Here are some of the treatments that require preauthorization:

- Medical evacuation
- Planned inpatient or day patient treatment (hospitalization)
- Any pregnancy or childbirth treatment (except for routine prenatal checks)
- Planned surgery
- Home nursing charges
- Outpatient psychiatric treatment
- Planned MRI, PET and CT scans
- Physiotherapy/physical therapy (10 sessions or more)

All preauthorizations must be requested before treatment or services are received or costs are incurred. If it's not possible to request preauthorization for an emergency, please be sure to notify us within the first 24 hours. You can find full details in your "My Claims" section of Health Hub.

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

Definitions

Accident: An unexpected, unforeseen and involuntary external event resulting in injury occurring while your certificate is in force.

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

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

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

Appliances: Devices and equipment when used as an integral part of a surgical procedure which are administered by a physician or specialist physician. Example: pace maker.

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

Benefits: The insurance coverage provided by this policy and any extensions or restrictions shown in the Schedule of Coverage or in any endorsements (if and where applicable).

Bodily Injury: Injury, which is caused solely by an accident which results in the enrolled person's dismemberment, disablement or other physical external injury.

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

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

Coinsurance: The percentage of the total value of the incurred expenses for which the enrolled person is responsible for each and every medical condition for each period of coverage.

Commencement date: The date shown on the Schedule of Coverage on which coverage under this policy commences. For the purpose of this policy, coverage starts from 00:01 a.m. on the date shown on the Schedule of Coverage.

Congenital anomaly: Any genetic, physical or biochemical (metabolic) defect, disease or malformation (which may be hereditary or due to an influence during gestation), which may or may not be obvious at birth).

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

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

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

Country of residence: The country in which the enrolled person has his/her habitual residence (residing for a period of no less than six months per period of coverage) at the time the Schedule of Coverage is first issued or at each subsequent renewal date.

Date of entry: The date shown on the Schedule of Coverage on which an enrolled person was first included under the certificate.

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

Deductible: The amount payable by an enrolled person in respect of expenses incurred for treatment before any benefits are paid under the certificate for each period of coverage.

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

Dependent: A person that satisfies the requirements for enrollment. An eligible person is one who is either your spouse or adult partner, or your unmarried children who are not more than 18 years old and residing with you, or your unmarried children who are not more than 23 years old if in full-time education, at the date of entry or at any subsequent renewal date. Children under the age of 18 years old not residing with you will be accepted for coverage providing the application is signed by a legal parent or guardian. (The term "partner" shall mean husband, wife or the person permanently living with you (whether or not of the same sex) in a similar relationship). All eligible persons must be named as enrolled persons in the Schedule of Coverage.

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

Direct-settlement network (only available in certain countries): The medical providers where enrolled persons are able to obtain treatment for valid medical conditions and where the expenses will be settled directly by us. Enrolled persons are still responsible for any applicable copay, coinsurance or deductible which must be settled directly with the medical providers at the time of treatment.

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

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

Emergency: A sudden, serious, unexpected and unforeseen condition or illness that causes severe symptoms requiring immediate medical care, and constituting a hazard for life, health or physical well-being.

Enrolled person: You and/or the eligible persons identified in the Schedule of Coverage as an "enrolled person."

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

Group/coverage holder: An aggregate that is comprised of a minimum of three employees of the coverage holder.

Group administrator: A person authorized to act on behalf of the group.

Health care provider: A health care provider that has contracted to supply services for a pre-agreed charge and is included in our directory of medical facilities named as preferred care providers. You are entitled to ask us for a list of preferred care providers. Providers accepting direct-settlement are listed on our website under Member Downloads & Links.

Hereditary: A disease or disorder that is inherited genetically.

Home health care: Treatment made in the home of the enrolled person.

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

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

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

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

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

Insurer: Aetna Life & Casualty (Bermuda) Ltd.

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

Medical condition: Any injury, illness or disease including psychiatric illness.

Medical facility: A hospital, hospice or convalescent facility that:

a) Provides 24-hour nursing care by qualified nurses.

b) Is supervised full-time by a physician.

c) Has at least one physician on call at all times.

d) Keeps a complete medical record of each patient.

e) Has a full-time administrator.

f) Meets any licensing or certification standards of the country where it is situated.

g) Is a fee-charging establishment.

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

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

Oncology: 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.

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

Outpatient treatment: Treatment of an enrolled person by a physician or specialist physician, but where the enrolled person is not admitted to a bed in a medical facility.

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

Period of coverage: The period of coverage set out in the Schedule of Coverage. This will be a 12-month period starting from the commencement date or any subsequent renewal date.

Physician: A person who has attained primary degrees in medicine or surgery by attending a medical school recognized by the World Heath Organization and who is licensed by the relevant authority to practice medicine in the country where the treatment is given.

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

Policy: Our contract of insurance with you providing coverage as detailed in the Schedule of Coverage. The application form and Schedule of Coverage form part of the contract and must be read together with this policy.

Prosthesis: An artificial body part. Under this policy, prosthesis will be limited to an artificial limb or eye.

Psychiatric physician: A physician specializing in psychiatry or who has the training or experience recognized in the country in which they are a resident to do the required evaluation and treatment of psychiatric illness.

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

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

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

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

Renewal date: The annual anniversary of the commencement date.

Room and board: Charges made by a medical facility for the provision of a room, bed and other necessary services made on a daily or weekly standard private room rate.

Schedule of coverage: The schedule giving details of the enrolled person eligible for coverage, the benefits applicable and any extensions, restrictions or endorsements applicable.

Sound natural teeth: Teeth that were stable, functional, free from decay and advanced periodontal disease, and in good condition at the time of the accident.

Specialist physician: A registered physician who:

a) Currently holds a substantive consultant appointment in that specialty in a medical facility;

b) Currently holds a substantive consultant appointment which we on professional advice or medical advice accept as being of equivalent professional status, or

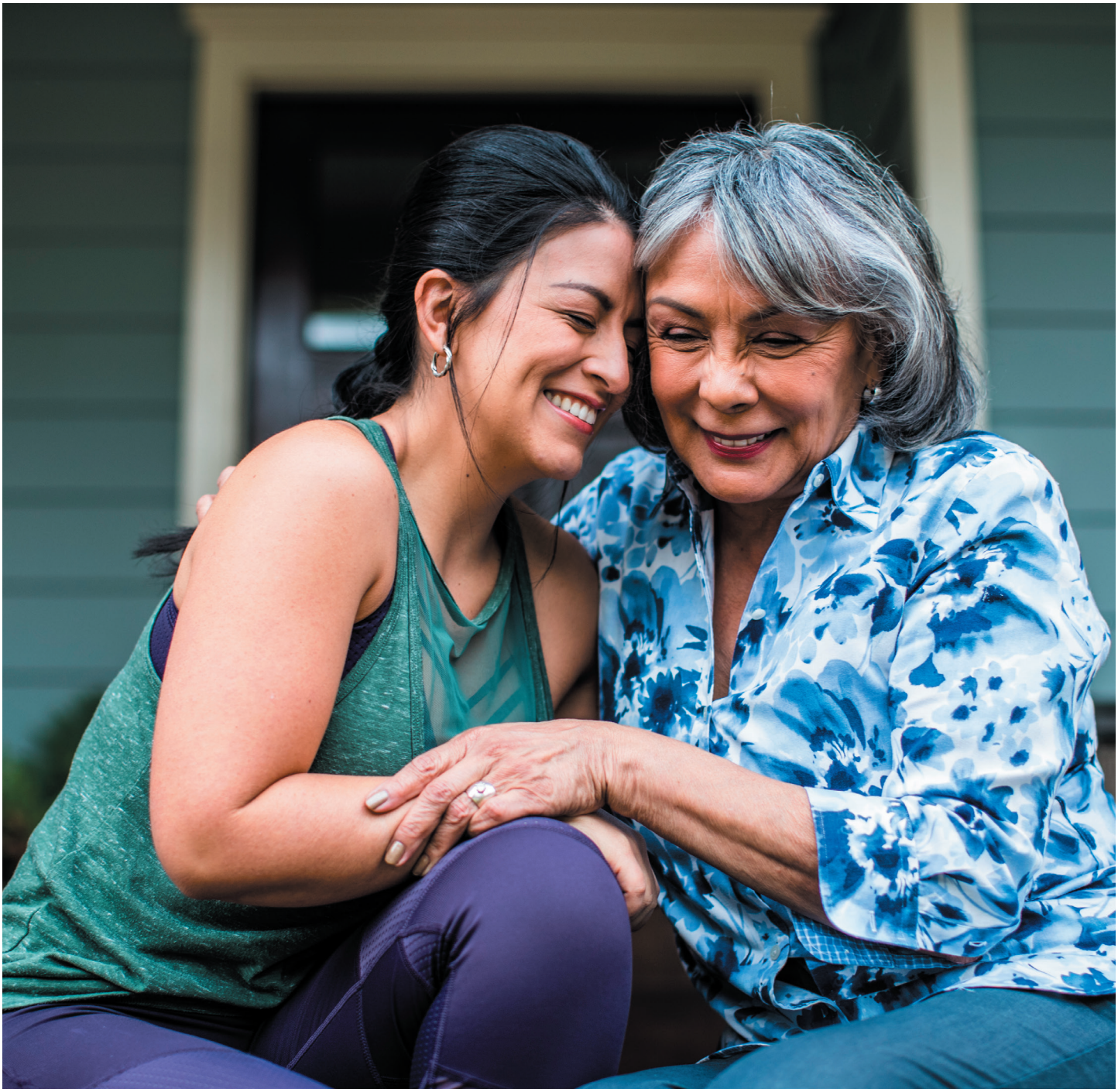
c) Is recognized as such by the statutory bodies of the relevant country.

Treatment: Surgical, medical or other procedures, the sole purposes of which are the cure or relief of a medical condition.

Terminal illness: A medical prognosis of six months or less to live.

We/our/us: Aetna Life & Casualty (Bermuda) Ltd, trading as Aetna International.

You/your: The person identified in the Schedule of Coverage as the enrolled person who applied for enrollment in the policy.



Benefits and general conditions

Benefits

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

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

General conditions

1. Other insurance:

In order for Aetna to apply benefits as a secondary insurer, the following is required:

a) Explanation of Benefits (EOB) from the prior carrier

b) Itemized bill from provider

c) Medical report — in some circumstances/depending upon treatment

d) Completed claim form

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense. In addition, any amount paid by this plan as a secondary plan, will be subject to this plan's limitations, exclusions and any required deductible or co-insurance.

2. Policy:

Your application form, your Schedule of Coverage and the Member Handbook must be read as one, as they form the basis of your coverage with us.

3. Subrogation clause:

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

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

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

4. Family/dependent coverage:

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

with this condition will result in the termination of your coverage and that of all enrolled persons.

5. Acceptance clause:

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

6. Eligibility:

New applicants will be eligible for coverage until the age of 65. Individuals over the age of 65 are not eligible for coverage unless the enrolled person's date of entry was prior to their 65th birthday. Also, all coverage will terminate if your country of residence is the United States or Bermuda, at the time of application for enrollment or during any period of coverage.

7. Compliance with policy terms:

We are not liable for any claim in the event of any failure by an enrolled person to comply with its terms and conditions, except where the circumstances of any claim are unconnected with such failure and no fraud is involved.

8. Change of risk:

You must inform us as soon as reasonably possible of any material changes related to any enrolled person that affects information given with your application for enrollment. We reserve the right to alter the terms of your Schedule of Coverage or cancel coverage for an enrolled person following a change of risk.

9. Policy duration and premiums:

a) The coverage provided is for one-year and is renewable for successive one year periods, subject to the terms in force at the time of each renewal date and to payment of the premium.

b) The premium payable may be changed by us from time to time. If the insured moves into a higher age band, the premium will increase at the next renewal date.

c) All premiums are payable in advance before we provide coverage under this policy.

d) The policy is an annual contract and you are responsible for the whole year's premium even if we have agreed that you may pay by installments.

10. Medical evaluations:

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

11. Break in coverage:

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

12. Children:

Newborn children are accepted for coverage from birth. Acceptance of newborn babies is subject to your written notification within 30 days of birth and our receipt of the full premium within another 30 days following notification. If a newborn is not added within the first 30 days of birth, they will be subject to underwriting. Their effective date will be the acceptance date, not their date of birth.

Children who are not more than 18 years old residing with you, or 23 years old if in full-time education, at the date of joining or at any annual renewal date will be accepted for coverage. Children under the age of 18 years old not residing with you will be accepted for coverage provided the application is signed by a legal parent or guardian. The premium applicable will be the 18 – 21 age band rate.

A declaration of health is required for all dependents that are born following assisted conception. We reserve the right to reject any application without giving reason.

13. Alterations:

a) We may alter the terms and conditions of enrollment at any renewal date. A copy of the amended Member Handbook will be sent to you at such time. You may cancel enrollment within 15 days following any renewal date, and provided you have not made a claim, we will refund your premium. We will give you reasonable notice of such alterations. We will send details of such alterations to your last address on file with us. However, the alterations will take effect even if you do not receive it for any reason.

b) No alteration or amendment to the policy or the Member Handbook terms will be valid unless it is in writing from us and signed by an authorized representative of the insurer.

14. Waiver:

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

15. Cancellation:

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

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

a) Misled us by misstatement.

b) Knowingly claimed benefits for any purpose other than as are provided for under this policy.

c) Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to our detriment.

d) Otherwise failed to observe the terms and conditions of this policy or failed to act with the utmost good faith.

e) Changed country of residence so that, for the purposes of the policy, the country of residence becomes the United States or Bermuda.

16. Applicable law:

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

17. Language:

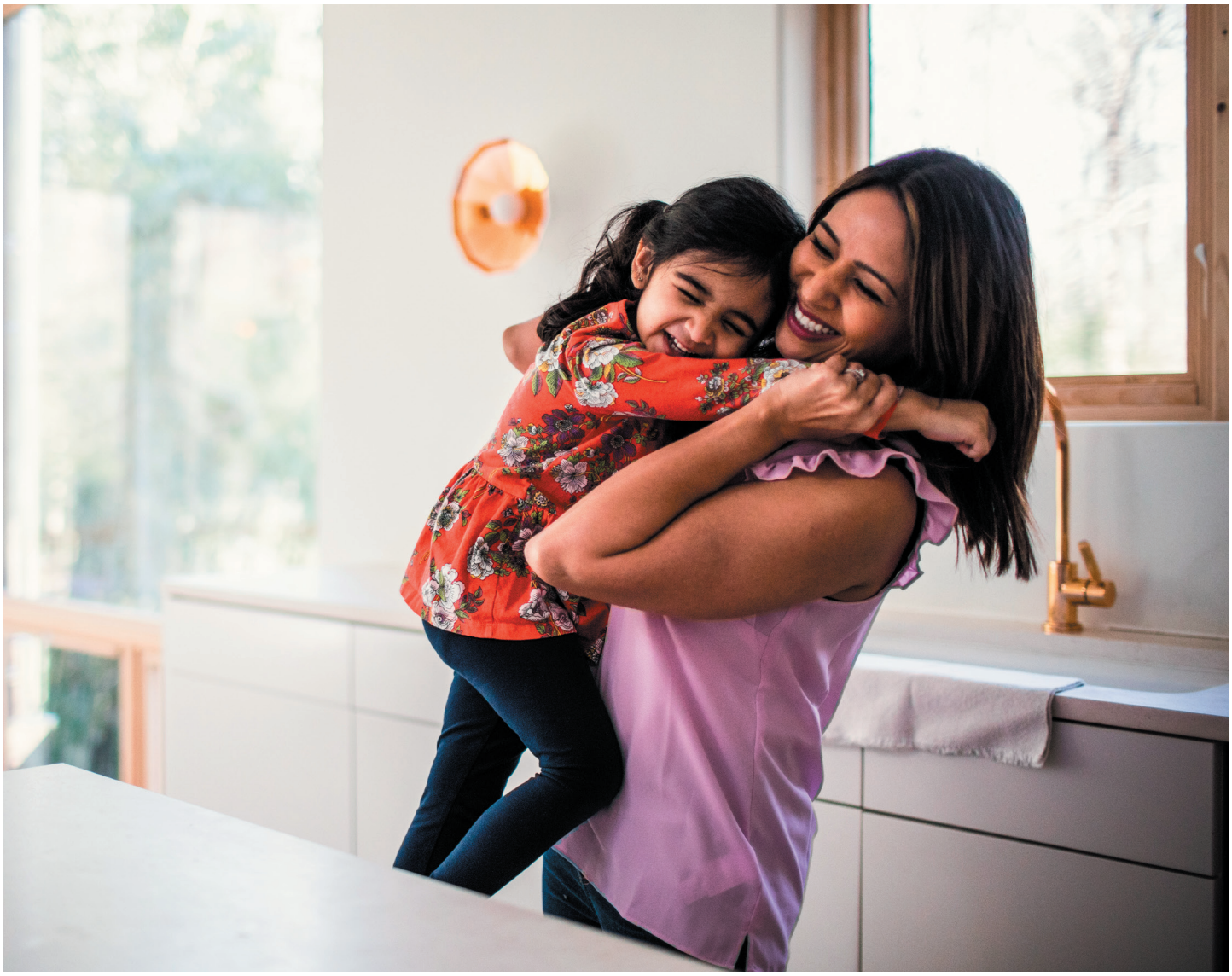
This contract may only be completed in English.

18. Transfers/enhanced coverage:

When you transfer to the Mobile Healthcare Plan from any of our other existing plans, or, while covered under the Mobile Healthcare Plan, you apply for and receive any enhanced benefits or coverage (such as inclusion of an option at any renewal date), any enhanced benefits, coverage or maximum refundable amounts are restricted to new medical conditions which have not been previously suffered from, whether or not diagnosed, occurring after the date of transfer.

19. Fraudulent/unfounded claims:

If any claim is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable. In addition, all coverage in respect of the member shall be cancelled void from the commencement date without refund of premiums.



20. Liability:

Our liability shall cease immediately upon termination of enrollment under your Schedule of Coverage for whatever reason, including, without limitation, non-renewal and non-payment of premium.

21. Premium refunds:

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

22. Death of certificate holder:

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

23. Entire contract — changes:

The policy, including the Schedule of Coverage, application for enrollment and Member Handbook constitute the whole contract and cannot be changed by anyone other than us. Such approval must be endorsed or attached to the Schedule of Coverage. No agent or broker can change the policy or the Schedule of Coverage or waive the terms of either document.

24. Claim notification:

Please ensure that your claim form is completed in full and returned within 180 days of the date of treatment. We reserve the right to reject any claim that is not submitted within 180 days of the date treatment took place. Refer to the Claims Procedures section within this document for more detail.

Exclusions

This policy does not cover expenses arising from:

1. Any medical condition or related condition for which the enrolled person has received treatment, had symptoms of, or sought advice for prior to the enrolled person's date of entry (pre-existing medical condition), unless it had been declared as a material fact at the time of application and accepted in writing by us.

2. Treatment that we determine on medical advice is either experimental or unproven.

3. Self-treatment, or treatment provided by a direct family member. This includes, but is not limited to, prescribed or non-prescribed medication, diagnostic tests and surgical procedures.

4. Any congenital anomalies where symptoms exist or where advice has been sought prior to your date of entry unless the enrolled person is an infant up to the age of 12 months.

5. Normal hearing tests and any corrective surgery for non-medical/natural degenerative hearing defects. Non-medical/natural degenerative eye defects including, but not limited to, myopia, presbyopia and astigmatism and corrective surgery for sight defects not incurred as a result of an accident. Normal eye tests are excluded.

6. Convalescence, unless it forms an integral part of treatment received as an inpatient and is under the control or supervision of a specialist physician and is undertaken in a recognized convalescent facility or as home health care.

7. Treatment received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a medical facility or nursing home attached to such establishments or a medical facility where the medical facility has effectively become the enrolled person's home or permanent abode or where admission is arranged wholly or partly for domestic or social reasons.

8. Cosmetic treatment is as follows — Cosmetic treatment, and any consequence thereof.

9. 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.

10. Alternative medicines including, but not limited to, chiropodists, optometrists, lactation examiners and podiatrists. Coverage is extended to include chiropractors, osteopaths, homeopaths and acupuncturists only, as provided for under the "Outpatient Treatment Charges" of the Schedule of Benefits.

11. 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.

12. Any second or subsequent medical opinions from a physician or specialist physician for the same medical condition unless it has been authorized by us in writing.

13. Pregnancy terminations on non-medical grounds, antenatal classes, midwifery costs when not associated with delivery or a recognized medical condition, and costs associated with amniocentesis (or associated/similar procedure).

14. Treatment directly or indirectly arising from or required in connection with male and female birth control, infertility, contraception, sterilization (or its reversal) and any form of assisted reproduction or any complication or pregnancy arising as a result of assisted pregnancy or fertility treatment.

15. Treatment of impotence or any related condition or consequence thereof.

16. Treatment directly or indirectly associated with a sex change and consequence thereof.

17. Venereal disease or any other sexually transmitted diseases or any related condition other than HIV/AIDS as provided for under the AIDS benefit noted on your Benefits Schedule.

18. Orthodontic treatment, gingivitis and periodontitis or any related condition.

19. Dental implants

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

21. Treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy, developmental and social and behavioral problems.

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.

23. Suicide or attempted suicide, bodily injury or illness, which is willfully self-inflicted or due to negligent or reckless behavior.

24. Any injury sustained directly or indirectly as a result of the enrolled person acting illegally or committing or helping to commit a criminal offense.

25. 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.

26. Costs and expenses incurred where an enrolled person has traveled against medical advice.

27. The fees of a religious practitioner in respect of the mortal remains benefit.

28. Treatment and expenses directly or indirectly arising from or required as a consequence of: war, invasion, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege or attempted overthrow of government or any act of terrorism, unless the enrolled person sustains bodily injury while an innocent bystander resulting from an act of terrorism only up to a maximum amount U.S. of $50,000 per enrolled person per incident.

29. Regardless of any contributory clause(s), this insurance does not cover treatment of a medical condition that is in any way caused or contributed to by an act of terrorism involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent. If we allege that by reason of this exclusion any claim is not covered by the insurance, the burden of proving the contrary shall be upon you.

30. Treatment directly or indirectly arising from or required as a result of chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel, asbestos or any related condition.

31. Treatment received in connection with insomnia, sleep disorders, sleep apnea, fatigue, jet lag or work-related stress or any related condition.

32. Dietary supplements and substances that 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.

33. Home visits by a physician, specialist physician or qualified nurse unless specifically agreed by us in writing prior to consultation.

34. Any treatment not prescribed, recommended or approved by the enrolled person's attending physician or specialist physician.

35. Costs for treatment that the enrolled person is not legally obliged to pay.

36. Costs, as determined by us, to be for custodial care.

37. Costs, as determined by us, to be for hospice care.

38. 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 1.5 miles; skiing off-piste or any other winter sports activity carried out off-piste; and Arctic or Antarctic expeditions.

Limits of coverage

1. Deductibles:

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

a) Preferred care deductible (includes treatment outside of the United States): All costs for eligible treatment received outside of the United States and any eligible treatment received by a preferred care provider within the United States will apply toward the deductible. The enrolled person will be required to meet the costs of this treatment up to the preferred care deductible. Once the cost of the enrolled person's treatment exceeds the preferred care deductible, the policy will begin paying benefits for eligible treatment outside of the United States and eligible treatment by a preferred care provider within the United States.

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

2. Coinsurance limits:

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

3. Application of limits:

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

4. Schedule of limits/maximums:

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

5. Accumulation:

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

Claims procedures

International Member Service Center:

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

To obtain assistance from the International Member Service Center, use the contact details on your Aetna membership ID card. You will need to provide:

- Your name
- Policy number
- Telephone and/or fax number
- Location and medical condition

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

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

Preauthorization:

You may need to obtain prior approval (preauthorization) before certain types of treatment. In these instances, it's important to start the process early to prevent delays or denial of your claims. The best place to start is to talk with your provider about their process for preauthorization. In some cases, they may take care of it for you. If the provider instructs you to obtain it on your own, just give us a call at the number on your Aetna ID Card.

Here are some of the treatments that require preauthorization:

- Planned inpatient or day patient treatment in a hospital
- Any pregnancy or childbirth treatment (with the exception of routine prenatal checks)
- Planned surgery
- Home nursing charges
- Planned MRI, PET and CT scans
- Infertility treatment (if purchased)
- Outpatient psychiatric
- Emergency evacuations (will be handled by the CARE team) If you require emergency treatment, please do not delay treatment.

Planned inpatient and day patient treatment:

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

i) Contact the International Member Service Center (toll-free or collect) at least five business days prior to admission, giving full details of the condition, proposed treatment (including dates and name of procedure, if known), the name of the specialist physician and details of the medical facility. (The telephone number is provided on your membership card).

ii) The International Member Service Center will advise you if they have sufficient information to confirm the enrolled person's coverage. If not, they will advise you what further information is required.

iii) The International Member Service Center will verbally confirm the enrolled person's coverage and will dispatch written confirmation to you.

iv) The International Member Service Center will attempt at all times to make arrangements with the medical facility for all eligible bills to be settled directly. Where this has been arranged, you should send the original claim form and the unpaid invoices (if given to you by the medical facility) to Aetna.

Emergency admissions:

In the event of emergency admissions, you must contact the International Member Service Center within 48 hours of admission and follow the steps described earlier for inpatient treatment. Failure to contact the International Member Service Center within 48 hours of admission
will result in treatment or any evacuation cost only being reimbursed at 50 percent of the costs incurred within the terms of the certificate. Please do not delay in obtaining emergency treatment.

Outpatient treatment:

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

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

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

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

Guarantee of Payment (GOP)/precertifications:

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

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

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

Currency:

If, acting reasonably, we determine that any central bank or relevant government or governmental authority imposes an artificial exchange rate (including without limitation an exchange rate which is inconsistent with the free market exchange rate) in relation to a relevant currency for any reason, we may in our sole discretion reimburse you for your valid claims incurred in that country in any manner we may reasonably decide. In making such determination we shall seek to ensure that we indemnify you for your loss (subject to the terms and conditions of your policy), but do not unjustly enrich you as may have been the case had we applied such an artificial exchange rate to pay you in the plan currency. We will reimburse you in (i) the applicable local currency, or (ii) if you do not have a bank account in such local currency, in the plan currency in an amount equal to the applicable Reasonable and Customary Charges, subject in each case to the principle of indemnity we mention above.

General claims information:

Here are some important things to keep in mind when submitting a claim:

- We may deny any claim not submitted within 180 days of the treatment date
- Make sure to provide all necessary supporting documents including original receipts, certificates and x-rays
- Keep your original receipts on file in case they are needed for verification purposes
- Include your Aetna ID number on each document submitted with your claim form
- Make sure to indicate the country and currency you would like to be reimbursed in
- Provide complete details on the description of service and the reason for the visit
- If you submit a claim for any of the following treatments, we will need a referral letter from your medical practitioner or specialist:
  - Chiropractic treatment
  - Acupuncture treatment
  - Osteopathic treatment
  - Homeopathic treatment
  - Podiatric treatment
  - Physiotherapy (additional referral by a specialist required after 10 sessions)

All claims should be sent to:

Aetna International
P.O. Box 981543
El Paso, TX 79998
USA

Toll free: **+1-866-545-3252** (inside USA only)
Telephone: **+1-813-775-0220**
Fax: **+1-860-262-9111**
Email: **AmericasServices@aetna.com**

Complaints procedure:

Our aim is at all times to provide a first-class standard of service. However, there may be occasions when you feel this objective has not been achieved. Should you have a complaint regarding this insurance policy, please contact in writing Aetna International as shown above.

AetnaInternational.com

46.02.586.1-AM C (7/21)