What’s inside?

Before you join us

1. Introduction
2. Eligibility and material facts
3. Plan currencies, premiums and ways to pay
4. Your plan start date and cooling off period
5. Areas of cover
6. Clinical policy bulletins
7. Help us prevent fraud

While you’re with us

8. Making changes to your plan
9. Adding and removing dependants
10. Transferring dependants onto your plan
11. Cancelling your plan
12. What happens if you die
13. Claims
14. Exclusions

Staying with us

15. How to renew your plan

The extra bits

16. Definitions
17. Governing law, jurisdiction and language
18. Complaints
19. Data protection
Before you join us

1 Introduction
This Handbook, and the relevant Benefits Schedule, details what we do and don’t cover under our Aetna Pioneer plans, as well as giving you important information about managing your plan.

Please read this information carefully to make sure you’re completely satisfied with the cover we’re providing and that it meets your needs. If you have any questions, please contact us and we’ll be more than happy to help.

We do not guarantee that your plan meets the visa and/or social health care requirements of the country you’re moving to. It’s your responsibility to ensure that any plan you choose meets your needs. Please ask us or your broker if you have any questions.

If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic 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 other applicable economic 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 Asset Control (OFAC) license. For more information on OFAC, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Important information
Section 25(S) 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.

2 Eligibility material facts
Our plans and add-on plans are available to people of most nationalities, depending on where they reside. 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. If you are a US citizen and your chosen area of cover is Area 1, only Aetna Pioneer 5000+ is available to you.

If you are not a US citizen and your chosen area of cover is Area 1:
• If you don’t live in the US, Aetna Pioneer 5000 and 5000+ are available to you
• If you do live in the US, only Aetna 5000+ is available

If you choose Area 2, 3, 4, 5, 6 or 7, Aetna Pioneer 1750, 2500, 4000 and 5000 plans are available to you.

If you are a US taxpayer, please read the ‘Cover in the US’ section in this Handbook for more information, as this plan may not satisfy the requirements of the U.S. Patient Protection and Affordable Care Act and therefore you may be subject to tax penalties.

Age
To be eligible for our plans, you must be at least 18 and no more than 79 years old on your start date. If you add dependent children to your plan, they must be unmarried and either aged under 18 or aged 18 to 26 and in continuous full-time education at their start date. For the latter, we may ask you to send us proof from their educational facility.

Our add-on plans have additional eligibility criteria – you’ll find more details in the applicable Benefits Schedule.

Material facts
You must tell us all material facts and check that they are correct before we accept an application, make changes to your plan or renew it. If you’re not sure whether a fact is material, please ask us. Moratorium cover will still apply even if you tell us about any pre-existing medical conditions you might have.

You must let us know in writing immediately if any material facts change. For example, if you change your name, occupation or address. We may apply new terms to the plan, void or cancel it and/or reduce or reject any related claims, based on your new material facts.

Voiding your plan
We’ll void your plan from its start date, renewal date or change date, if you:
• deliberately or recklessly give us inaccurate or incomplete material facts, or
• don’t take reasonable care to give us accurate and complete material facts and we wouldn’t have covered you had we known about the material facts.

If we void your plan, we can continue to offer your dependants cover if:
• a dependant who is 18 years old or more writes to us to appoint themselves as the new planholder, or
• you write to us to appoint a parent or legal guardian to act as the new planholder. The new planholder will manage the plan but we won’t cover the person.

You must appoint a new planholder within seven days of us telling you that we’ve voided your plan, otherwise we’ll cancel the entire plan from the void date.

Cover in the US
Your plan is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). As such, your plan 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 to you.

You may wish to consult with your legal, tax or other professional adviser for further information. This is only applicable to certain eligible US taxpayers.

Accordingly, we reserve the right to cancel your cover immediately if you have Area 1 cover and you are:
• a US citizen residing in the US for 36 days or more (consecutively or in aggregate) during any 12 month period; or
• not a US citizen and you spend more than 183 days (consecutively or in aggregate) in the US over three plan years.

3 Plan currencies, premiums and ways to pay

When you take out your plan, you can choose from the currencies available on your application form. You must pay all premium in the same currency as your plan. Your cover won’t be able to start until we’ve received your premium (which must be on or before the premium due date).

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

You can pay your premium in a single annual payment or by quarterly or monthly instalments, depending on the plan you choose and the method you wish to pay by.

Paying by card

Pay annually
To pay annually by debit or credit card, contact us by email or telephone, or fill in the Card authority in your application form.

Paying by bank transfer

Pay annually
To pay annually by bank transfer, you’ll need your quotation number or plan number to hand. Follow the instructions on your application form.

Paying by cheque or banker’s draft

Pay annually
Your invoice will show details of how much to pay. When paying by cheque or banker’s draft, you must give your full name and the quotation number or plan number as the reference.

Unpaid or late premiums
We’ll write to tell you if we haven’t received or haven’t been able to collect your premium on time.

We’ll cancel your plan if we don’t receive payment within 30 days of the premium due date. You’ll then have to apply for a new plan if you would still like us to cover you. Your premium and terms may change and you’ll lose any existing Healthy Behaviours Discount from your cancelled plan (see section 13 Claims).

4 Your plan start date and cooling off period

Your plan will start on the plan start date you request; this date will show on your Certificate of Insurance. Your plan will cover you for 12 months until your plan renewal date, unless you cancel your plan.

Cooling off period
You have the right to cancel your plan for any reason by writing to us or calling us within 15 days of receiving your plan documentation, or the plan start date, whichever’s later.

We’ll refund your premium in full if you haven’t (and any other member hasn’t) made a claim under the plan. If you’ve made a claim and we haven’t paid you or a medical provider for it, we’ll refund your premium and cancel any unpaid claims.

However, if you have (or any other member has) made a claim and we have paid for it, we won’t refund your premium and you must still pay us any unpaid premium due for the remainder of the plan year.

We can only refund premium to the bank account or card you originally paid from. You’ll be responsible for any shortfall from exchange rate differences and any bank charges.

To cancel your plan after the 15 day cooling off period, see section 11 Cancelling your plan.

5 Areas of cover

Area 1
Includes all of the countries and territories in the world, including all countries and territories in Areas 2, 3, 4, 5, 6 and 7, plus the US

Area 2
Includes the countries and territories listed below and all countries and territories in Areas 3, 4, 5, 6 and 7

American Samoa
Antarctica
Bouvet Island
British Indian Ocean Territory
Canada
Christmas Island
Cocos (Keeling) Islands
Cook Islands
East Timor
Fiji
French Polynesia
French Southern Territories
Guam
Heard Island & McDonald Islands
Hong Kong
Kiribati
Macau
Marshall Islands
Micronesia, Federated States of Nauru
New Caledonia
Niue
Norfolk Island
Northern Mariana Islands
Pitcairn
Russian Federation
Saint Helena, Ascension & Tristan da Cunha
Saint Pierre & Miquelon
Samoa
Solomon Islands
South Georgia & the South Sandwich Islands
Tokelau
Tonga
Tuvalu
United States Minor Outlying Islands
Vanuatu
Wallis & Futuna

Area 3
Includes the country listed below and all countries and territories in Areas 4, 5, 6 and 7

China
## Area 4
Includes the countries listed below and all countries and territories in Areas 5, 6 and 7

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## Area 5
Includes the countries and territories listed below and all countries and territories in Areas 6 and 7

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Clinical policy bulletins

For information on how we classify certain treatments and services, visit aetna.com/health-care-professionals/clinical-policy-bulletins.html. Our clinical policy bulletins (CPBs) are based on objective and credible sources, including scientific literature, guidelines, consensus statements and expert opinions.

They’re not a description of cover or confirmation that we cover these treatments, services or costs under your plan. If there’s a discrepancy between a CPB and your plan, your plan terms will apply.

Help us prevent fraud

Fraud is a crime and health care fraud increases premiums for our customers. With your help, we’ll do our utmost to detect and eliminate it.

Health care fraud includes:
• giving false or misleading information to get insurance or a premium reduction
• claiming for treatments or services that you haven’t received
• altering or amending invoices or bills
• giving a false diagnosis
• claiming from more than one insurer for the same treatment or service
• using somebody else’s insurance to get treatment or services.

How you can help protect yourself and keep premiums down

There are simple steps you can take to protect yourself from health care fraud, including:
• comparing invoices with your records, checking dates are correct and that you received the treatments or services shown
• asking questions if there’s anything you’re unsure about, don’t understand, expect or recognise
• keeping in touch with us when you’ve made a claim
• letting us know if you’re concerned your doctor is giving you unsuitable treatment
• filing in claim forms carefully
• looking after your insurance details and documents and keeping copies of any correspondence
• making sure you understand any documents before you sign them
• reporting suspected fraud to us.

We work closely with others to prevent fraud

We’re committed to protecting you against fraud and also have statutory responsibilities to prevent our products from being used for financial crime. We work with other bodies such as international insurance bodies, international police, investigative agencies and government departments to do this.

If you suspect fraud

Contact us as soon as you can.

Call our confidential Fraud and Investigation line on +44-(0)1252-896-383 or email IGUKfraudgovernance@aetna.com.
While you’re with us

8 Making changes to your plan

Notifying us of changes

When you request to make a change to your plan, you must take reasonable care when answering any questions we ask – please read section 2 Eligibility and material facts for more details. You must tell us immediately in writing about changes to the following and when such changes will take (or have taken) place:

• name or gender of a member
• occupation of a member
• address of a member, particularly if this is a change to the country in which a member lives, or
• any information given to us by you in relation to your application and/or any changes since.

After you tell us about a change, depending on the nature of the change, we may:

• charge you additional premium (including any applicable tax)
• change the relevant member’s benefits
• apply different terms to the relevant member’s coverage under the plan
• cancel the relevant member’s coverage under the plan
• send you a new Certificate of Insurance and a new Member ID card (or cards, if there are other members), or
• reassess or reject any related claim of the relevant member.

Note that we may charge you an administration fee to replace any plan documentation or Member ID card.

You can’t change the following during your plan year, but you can write to us to ask us to change these when your plan renews for the next year:

• your plan level
• your optional benefits including taking out an add-on plan
• your excess or coinsurance
• your plan terms, or
• your plan currency.

You must tell us all material facts when making a change.

9 Adding and removing dependants

Adding a dependant

With our agreement you may add a dependant to your plan after the plan start date. Please contact us and we’ll let you know the information you’ll need to provide us, which may include completing an application form for the dependant, and how we may change your premium as a result. We’ll send you your revised Certificate of Insurance and the new dependant’s Member ID Card each time we add a dependant to your plan.

Start dates for added dependants

If, on the date you contact us to add a dependant, that dependant is less than 31 days old and we have covered one of the dependant’s parents for a continuous period of at least 12 months, we’ll add the dependant to your plan regardless of the dependant’s health with effect from the dependant’s date of birth. There is no need to complete an application form.

To add any other dependant to your plan:

• if your plan has a moratorium, we’ll cover the dependant from the date on which you contact us or from a later date that you may request and a new moratorium will apply for that dependant. There is no need to complete an application form; or

• if your plan does not have a moratorium, we’ll (based on a completed application form for the dependant) either cover the dependant from the date on which you accept any terms we offer in relation to such dependant or decline to add the dependant to your plan. If we decline to add a dependant, we’ll explain to you the reason for this in writing.

The terms of your plan will apply to any dependant you add. Please note in particular exclusion 14.16 which excludes any inpatient treatment for an acute medical condition that begins before the dependant is eight days old if the pregnancy was achieved by assisted conception.

Removing a dependant

Please tell us in writing if you’d like to remove a dependant from your plan and we’ll do so. The dependant’s end date will be the date that we receive the request, or a future date that you have given.

You’ll also need to tell us if there are any outstanding claims for their treatment or services and if you’ve incurred any further costs in relation to your plan.

If there aren’t any claims paid or pending for any member on the plan, we’ll issue a pro-rated refund of the removed dependant’s premium.

If you’re waiting for us to approve or pay a claim, we can’t approve it unless we’ve received all premium for the entire plan year. If any member on the plan has made any claims that we have approved and paid, no refund will be issued and all premiums must be paid for the entire plan year.

When you remove a dependant, we’ll send you a new Certificate of Insurance to reflect such removal.
Transferring dependants onto your plan

If you’d like to transfer someone from another insurer to your plan, they’ll need to complete a Continuous Transfer Terms (CTT) application form and send us the original Certificate of Insurance or other evidence from their previous insurer which shows:

- their original start date with that insurer,
- their underwriting terms, and
- any special terms that may have applied.

If there’s a break between the end date of their previous insurance plan and their application, we won’t be able to offer a transfer on the same or similar terms as the previous plan.

If we accept the application, we may charge an increased premium. Their cover will begin on the date we receive your acceptance of any special terms we’ve applied, or on a future date you request following your acceptance of those terms, and we have agreed.

Cancelling your plan

You must write to us if you decide to cancel your plan. Your last day of cover will be the date we receive your written decision to cancel or on a future date you give us.

If no member has made any claims, or will make any claims, we’ll issue you a pro-rata refund of premium.

If we have not paid you the costs for any claims, but any member has made claims that we have not yet approved, or will make any claims, we won’t approve or pay these costs unless we have received all premium for the entire plan year. We’ll issue you a pro-rata refund of premium if you confirm to us, in writing, that you do not want us to approve any such claim.

If, before the cancellation date, a member has made a claim and we have approved it, we’ll only pay you the costs for any claim before the cancellation date when we have received all premium for the entire plan year. We’ll issue you a pro-rata refund of premium only if you pay any costs incurred before the cancellation date.

Claims

Should you have any questions concerning your claim, please contact our Member Services Team:

By telephone toll free on 1-800-723-1241 or by landline on +65-6701-6912.
By fax on +65-6593-8501.
Or by e-mail at AsiaPacServices@aetna.com

We’ll record all calls for monitoring and training purposes.

What happens if you die

If you die, the other members on the plan will be able to apply for continued cover under the plan by sending us a signed application form within four weeks of your date of death. We cannot guarantee cover, we may apply new terms and the premium may change.

Your personal representative can cancel the plan in writing. If you haven’t made any claims, we’ll issue a pro-rata refund of the premium once we’ve received a certified copy of your death certificate. We’re unable to issue premium refunds if we’ve paid a claim.

If you do not know the correct dialling code to use, you can refer to www.business.att.com/bt/access.jsp to find the number for the country you are dialling from. When prompted during the call please enter the access code 855-491-9160 and follow the instructions.

What can you claim for?

Only qualified medical practitioners, specialists, nurses or therapists with the aim of curing or substantially relieving your medical condition must treat you. Only psychiatrists or qualified and registered psychotherapists or psychoanalysts may give you psychiatric treatment, and only a medical practitioner or specialist can refer you for physiotherapy, podiatry, osteopathic and chiropractic treatment.

If the medical practitioners, specialists, nurses or therapists refer you for further diagnostic tests and procedures or treatment, you must start treatment within 90 days of the referral date for us to be able to pay your costs.

You must tell us about a claim within 180 days of receiving the treatment or services. If you leave it longer, we may not be able to reimburse you.

We’ll only pay reasonable costs for claims. Reasonable costs are the average cost of treatment, expertise or services given by similar types of medical provider within the same country or geographical region, based on our knowledge and experience.

We’ll pay for hospital accommodation (including meals) up to the cost of a standard single room with a private bathroom.

If you incur costs above the limits shown in your Benefits Schedule or you use a visiting doctor whose costs are higher than those of a medical facility’s in-house doctor, you’ll have to pay the difference.

Aetna Pioneer Handbook (The details)
What you need to know when claiming

We’ll email you a Member ID card (or cards, if there are other members) when your plan starts. You must show your Member ID card to the medical provider when you go for preauthorised inpatient treatment or daycare treatment (please see the section called ‘Requesting preauthorisation’ below for more details). If you’re entitled to direct settlement, you must show this card when getting outpatient treatment at a direct settlement facility.

You’ll need to quote your plan number and Member ID in all correspondence with us relating to your claim.

Keep copies of the information about your claim for your own records. We won’t be able to return any original claim documents to you after we’ve paid the claim.

We may ask you for more information to help us process your claim, and we may ask a specialist or medical practitioner of our choice to examine you.

We may also request further tests or evaluations if we decide that a medical condition may be directly or indirectly related to a medical condition we do not cover for. We may decline your claim if we don’t have sufficient information to assess it.

You must tell us about any negotiations or settlement discussions you enter into with any other party about any action or omission which leads to a claim under your plan. You mustn’t agree to a settlement with any party without our prior written agreement.

Requesting preauthorisation

Before you make a claim, please read your Benefits Schedule to make sure your plan covers the treatment you need.

You need to request preauthorisation before you receive any treatment or services, or incur any costs, if you want us to meet such costs in accordance with your plan for any of the following:

- medical evacuation
- inpatient treatment or daycare treatment admission
- 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
- single treatment or service that costs more than 500 USD or its equivalent in another currency

If it’s not possible to request preauthorisation in an emergency, you must notify us of the treatment or services within 24 hours. If you fail to notify us, we may pay only a portion of an eligible claim.

We’ll liaise with your medical provider during your claim. If necessary we’ll provide you with a ‘Release of medical information’ form. You’ll need to fill in this form to authorise your medical practitioner or specialist to release information to us about you under relevant data protection legislation.

If you have an eligible claim we’ll issue a letter of guarantee of payment to your medical provider. We’ll let you know as soon as possible if you have an ineligible claim.

When calling to request a preauthorisation, make sure you have your Member ID card to hand, your medical practitioner or specialist’s name and the medical provider’s name and telephone number.

If we give you preauthorisation, we’ll settle all eligible claims directly with your medical provider. If we are unable to settle your eligible claims directly, we will reimburse you instead.

Inpatient, daycare and outpatient direct settlement

If you’re admitted to a hospital which is in our medical provider network or you receive daycare treatment, we’ll take care of your eligible claims for such hospital bills. You don’t have to worry about paying large bills upfront. All you have to do is pay the relevant excess or coinsurance. If your plan benefits from outpatient direct settlement (which can be referred to as direct billing), we’ll pay your eligible outpatient bills directly to any medical provider which is in our medical provider network so that you’re not out of pocket. If the relevant medical provider is not in our medical provider network, we’ll reimburse you for any eligible claims instead.

How to make a direct settlement claim on an outpatient basis

You must:

1. Check that we cover your treatment under your plan; if you’re not sure, please contact us.
2. Visit a medical provider within our network for outpatient treatment.
3. Show your Member ID card to the relevant medical provider. The provider should then treat you and liaise with us to settle your claim (subject to point 4).
4. Pay any excess or coinsurance shown on your Member ID card or in your Benefits Schedule.

How to make a claim for outpatient treatment

You must:

1. See your medical practitioner, therapist or specialist in the usual way.
2. Ask your medical provider to complete the relevant section of the claim form which you can download from aetnainternational.com.
3. Pay your bill for the treatment you receive. Make sure you get an original itemised invoice and/or original receipt.
4. Or you can submit a claim online by completing the form and uploading scanned copies of any supporting documents to the ‘Claims Centre’ in the Health Hub.

You should send us these documents as soon as possible (and in any event no later than six months) after the first treatment date.
Ineligible claims

If you attend a direct settlement hospital, clinic or other medical facility in our medical provider network and we later determine that your claim is ineligible, we have the right to recover the full claim amount from you. If we pay a claim, it isn’t an indication of our acceptance of liability for the claim or confirmation that we’ll pay further costs for the same medical condition or related medical condition.

If we determine that a claim we’ve already approved is ineligible, we won’t pay for the claim. If we’ve already paid any costs, you’ll need to repay them to us within 14 days or we may withdraw any associated preauthorisation, cancel your plan and keep the premium. If you’d like us to reassess a claim we’ve rejected, you’ll have to prove that the claim is covered under the plan.

Stay healthy to save

If you are a member of an Aetna Pioneer 4000, 5000, or 5000+ plan, you can take advantage of our Healthy Behaviours Discount programme by logging in to the Health Hub. All you need to do is take the online Health Assessment so we can understand your current state of health. After that, we’ll give you a personalised action plan which aims to help you improve your health. If you take the Health Assessment every year and your plan stays claim-free for one or more plan year, you can enjoy a discount of up to 25% over five years.

Please note that in order to be eligible for the discount you must take the Health Assessment within 90 days before the renewal date of your plan. Also, if you submit an eligible claim for a previous plan year after we have given you a Healthy Behaviours Discount, we’ll remove the Healthy Behaviours Discount and you must pay the full, undiscounted premium before we can pay any of your claims.

Exchange rate

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 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. In either case, the reimbursement will be subject to the principle of indemnity we mention above.

Other insurance

If another insurer covers an eligible claim under your plan, we’ll deduct any payments you’ve received from the other insurer (plus any excess or coinsurance amounts under your other insurance plan).

Claims against third parties

If we have paid money to you (or to a medical provider on your behalf) in accordance with this plan, and you are entitled to receive money from any other party (including another insurer) for the same claim, we have the right to proceed against such other party in your name and to recover from you the money you receive (or have received) from such other party, up to and including the amount that we have paid.

You must notify us immediately in writing if you pursue or intend to pursue another party for such claim. We shall then decide whether or not to exercise our right under this section.

You must cooperate with us if we exercise this right.

Unless you have our prior written consent, you must not admit liability or fault to, or agree to a settlement with, such other party.
14 Exclusions

Your plan doesn’t cover claims for, arising from or connected to the exclusions in this section unless shown otherwise in your Benefits Schedule or we’ve agreed separately in writing, and we’ll seek to recover from you any payments we’ve made if we determine an exclusion applies to a claim we have already paid.

14.1 Acting against medical advice
Any journey, activity, action or pursuit you carry out (or omit to carry out) against medical advice.

14.2 Addictions and abuse
Treatment for alcohol, drug or substance abuse or any kind of addictive condition and any injury or illness associated with it. We define drug abuse as the use of any drug:
• in a manner or in quantities other than directed or prescribed by a medical professional, or
• for any reason other than what it was prescribed for.

14.3 Administrative costs, fees and charges
• completing claims forms,
• completing or obtaining other documents,
• hospital administration fees,
• any registration fees, or
• overdue invoice charges.

14.4 Altered and amended documents
Any invoice, claim form, medical report or other document that anyone has altered or amended.

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

14.6 Cosmetic treatment
Cosmetic treatment.

14.7 Certain costs you’ve incurred
Costs you’ve incurred if:
• they exceed the relevant Benefits Schedule limit,
• you haven’t completed the relevant waiting time shown in the Benefits Schedule, if applicable,
• they’re less than your excess or coinsurance,
• your plan doesn’t cover them, including associated costs such as loss of earnings as a result of a medical condition,
• you’ve incurred them outside your area of cover,
• you received treatment or services before the start date or after the end date of your plan.

14.8 False or fraudulent claims
False or fraudulent claims.

14.9 Gender reassignment
Treatment directly or indirectly associated with gender reassignment.

14.10 Harvesting, storage and organ transplants
The harvesting or storage of umbilical cord blood stem cells, sperm, mature oocytes and embryos.
Costs of:
• locating a replacement organ,
• removing an organ from a donor,
• transporting an organ, or
• any associated administration.

14.11 Illegal activities
You acting illegally or committing or helping to commit a criminal offence.

14.12 Innocent bystanders
Conflict or civil unrest if, in our reasonable opinion,
• you’re actively participating,
• you’re a member of any armed force or security service, including personal protection,
• you’ve knowingly entered or remained in a location where there is conflict or civil unrest, or
• you’ve intentionally put yourself at risk of injury.
A natural disaster if, in our reasonable opinion:
• you’ve knowingly entered or remained in a location where there is a natural disaster, or
• you’ve 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’ve knowingly entered or remained in a location where there is contamination,
• you’re a member of a biological, chemical or nuclear contamination cleaning crew of any kind, or
• you’ve intentionally put yourself as risk of contamination or injury.

14.13 Journeys and transportation
• any journey specifically made to receive treatment, unless you’ve requested preauthorisation and we’ve given our approval,
• non-emergency transportation, or
• costs for medical evacuations if a local situation makes it impossible, dangerous or not practical to enter a specific location or country.
14.14 Professional sports and hazardous activities
Playing professional sports (i.e. any sport or sports for which you are paid as your main source of income), or taking part in any of the hazardous activities below whether on a professional or recreational basis:
• Motor sports of any kind
• Using a weapon or firearm
• Mountaineering, potholing, spelunking or caving
• Trekking at an altitude of more than 2,500 metres
• Scuba or free diving, unless:
  – you are diving to a depth of less than 30 metres, and
  – you hold the appropriate PADI qualification or you are accompanied by a PADI qualified instructor
• Off-piste winter sports
• Arctic or Antarctic expeditions
• Being the driver or passenger of any motorised vehicle, including but not limited to a motorcycle, motorised tri-cycle or quad-cycle:
  – not on a public road, or
  – on a public road, unless you are wearing a seatbelt, if there is one, and the driver (whether you or somebody else) has the licence and insurance required by law to drive the motorised vehicle
• Being the driver or passenger of any motorcycle, motorised tri-cycle or quad-cycle, unless you are wearing a crash helmet.

14.15 Self-inflicted medical conditions
Suicide, attempted suicide or any deliberate self-inflicted medical condition.

14.16 Reproduction and newborns
Costs of:
• contraception or sterilisation,
• treatment for sexual problems including impotence,
• fertility or infertility tests or treatment,
• assisted reproduction,
• surrogacy,
• pregnancy, childbirth and postnatal costs whether complicated or not, including termination of pregnancy, or
• any inpatient treatment for an acute medical condition that begins before the member is eight days old if the pregnancy was achieved by assisted conception.

14.17 Sight, hearing and dental
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.
Orthodontic treatment which affects the structure, function, development or appearance of the teeth, upper or lower jaw or the oral cavity and dental implants.

14.18 Sleep
Sleep apnoea, sleep-related breathing disorders, snoring or insomnia.

14.19 Treatment provision and referral
• Treatment you receive before your start date or that is ongoing at your start date.
• Treatment that we determine on general advice is unproven, experimental or investigational.
• Drugs or dressings that:
  – the pharmaceutical regulator in your country of treatment doesn’t recognise,
  – you obtain without prescription, or
  – a medical practitioner prescribes for a medical condition that’s different to the one you’re claiming for.
• Substances, personal products and dietary supplements including vitamins, minerals, mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, children’s food, baby supplies and infant formula given orally.
• Home visits by a medical professional.
• Treatment in a spa, hydro spa, health farm or similar facility.
• Treatment at a nursing home or hospital that’s become your permanent residence or where you’ve been admitted for domestic reasons.

14.20 Underwriting terms
Moratorium
If your Certificate of Insurance shows that your underwriting terms are moratorium, this means your claim will not be paid if it’s relating to a pre-existing medical condition you’ve not had symptoms, needed or received treatment for, medication, a special diet or advice, or had any other indications of the condition.

Once you’ve completed a continuous 24-month period after your date of joining your pre-existing medical condition may be covered provided you’ve not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

Full Medical Underwriting
If your Certificate of Insurance shows that your underwriting terms are full medical underwriting, we will not pay a claim relating to a medical condition or symptom that you were aware of before your date of joining unless you told us about it on your application and your Certificate of Insurance doesn’t show an exclusion for that medical condition.
14.21 Weight management
Any treatment for weight loss or weight problems including bariatric procedures, diet pills or supplements, health club memberships, diet programmes or residential eating disorder programmes.

14.22 Durable medical equipment
Sight or hearing aids, furniture or any modifications to your personal or work environment.

14.23 Medical evacuation and local ambulance
Air-sea rescue, or any mountain rescue unless it’s for a medical condition you suffer at a recognised ski resort or similar winter sports resort.

14.24 Mortal remains
The purchase of a burial plot, or funeral costs, including, but not limited to, flowers and the funeral director’s fees.

15 How to renew your plan
If you’re eligible to renew, we’ll send you a renewal communication at least six weeks before the plan renewal date, which will include a renewal quotation, new plan documents and instructions on what to do next. The renewal quotation will show any changes to your plan and premium and explain how you can request changes to your plan.

Automatic renewal
If you pay your premium for your current plan by card or direct debit, we’ll automatically renew your plan unless you tell us in writing before your plan renewal date that you do not want to renew your plan. If the card or account details are no longer valid, we’ll ask you to provide new details so we can collect your premium.

Non-automatic renewal
Follow the instructions in your renewal communication to renew or request changes to your plan. If you do not want to renew, you don’t have to do anything, but that means your plan with us will end on the last day of your current plan year.

Staying with us

The extra bits

16 Definitions
Wherever we use the words ‘including’, ‘include’, ‘in particular’, ‘for example’ or any similar expression, any following information is given as an example only, not a full list, and will not limit the sense of the words, description, definition, phrase or term before those words.

Accident: any involuntary or unexpected event resulting in a physical injury.

Acute medical condition: 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 your chronic medical condition, which may respond to treatment that aims to return you to your state of health before the event occurred.

Add-on plan: a plan available in addition to your Aetna Pioneer plan that must have the same plan start date as your Aetna Pioneer plan.

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

Application: either:
• the document entitled ‘Aetna Pioneer plan application’ which you must complete and sign to agree to the terms of the plan plus any supporting information given in connection with it, or
• the information you supplied online and signed electronically to agree to the terms of the plan plus any supporting information given.

Area of cover: the geographic area or areas of the world in which you must receive treatment or services for your plan to apply. Your area of cover is shown on your Certificate of Insurance.
**Benefit**: the cover provided by your **plan** and shown in your **Benefits Schedule**, subject to any conditions or exclusions in your Handbook or shown on your **Certificate of Insurance**.

**Benefits Schedule**: the document that details the **benefits** available under your **plan**.

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

**Card**: Visa, MasterCard or American Express.

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

**Chronic medical condition**: 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 you to cope with it, or
- needs long-term monitoring including consultations, check-ups, examinations and tests.

**Claim**: your request for **us** to cover the costs of **treatment** or services under your **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**: the percentage of costs shown in your **Benefits Schedule** that you have to pay towards an eligible **claim**.

**Conflict or civil unrest**: Any act of terrorism, war, invasion, foreign enemy hostility, mutiny, riot, strike, civil war, rebellion, revolution, insurrection or attempted overthrow of government, usurped power, martial law or state of siege. An act of terrorism is considered to be any act by a 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.

**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.

**Continuous Transfer Terms (CTT)**: continuation of the same **underwriting** terms, including any special exclusions, that applied with your previous insurer. **You** will not be subject to any new personal **underwriting** terms. Cover will still be governed by the **benefits**, terms and conditions of the **plan** with **us**. The **underwriting** terms with **us** can be CTT previously MORI or CTT previously FMU. See the ‘Transferring dependants’ section and the CTT previously MORI and CTT previously FMU definitions for more information.

**Country(ies) of citizenship/nationality**: any country where you are a citizen or a national and entitled to hold a passport.

**Country of residence**: the country **you** live 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.

**CTT previously FMU**: continuation of your full medical **underwriting** terms with a previous insurer. Cover will still be governed by the **benefits**, terms and conditions of the **plan** with **us**.

**CTT previously MORI**: continuation of your **moratorium** start date if you had **moratorium underwriting** terms with a previous insurer. Cover will still be governed by the **benefits**, terms and conditions of the **plan** with **us**.

**Date of joining**: the date when **you** first enrolled, or re-enrolled if there is a break in your cover.

**Daycare**: **treatment** you receive when **you** are admitted to a **hospital** or **daycare** unit, and **you** do 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**: the **planholder’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 26 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 your signs or symptoms.

**Direct settlement**: where we settle costs of **outpatient** treatment or services directly with a medical provider in the medical provider network.

**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 date we cover **you** under your **plan**.

**Excess**: an amount **you** must pay towards the cost of part, or all, of a covered **claim** or **claims**.

**Full Medical Underwriting**: **underwriting** based on your medical history before your **date of joining**. Cover will still be governed by the **benefits**, terms and conditions of your **plan** with **us**. This includes the **underwriting** term CTT previously FMU.

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

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

**Home country**: the country **you**’re from, as given on your application.

**Hospita**: 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’s situated.
In-house doctor: a medical practitioner who is employed by the hospital as a permanent member of staff and charges in line with that hospital’s tariffs.

Inpatient: when treatment is received at a hospital and you need to stay in the hospital for one night or more.

Insurer: one of: Aetna Insurance Company Limited; Aetna Insurance Company Limited (Singapore branch); Aetna Insurance (Singapore) Pte. Ltd; Aetna Life & Casualty (Bermuda) Limited; Al Ain Ahlia Insurance Company; Al Khaleej Takaful Group; Archipelago Life Insurance Limited; Bahrain National Life Assurance BSC; BaoViet Insurance Corporation; Muscat Life Assurance BSC; BaoViet Insurance Corporation; Muscat Life Group; Archipelago Life Insurance Limited; Bahrain National Limited; Al Ain Ahlia Insurance Company; Al Khaleej Takaful Insurance (Singapore) Pte. Ltd; Aetna Life & Casualty (Bermuda) Insurance Company Limited (Singapore branch); Aetna

Intrinsic value: the cash value of an item at the time of loss or damage as reasonably calculated by us, including appropriate deductions for wear and tear.

Lifetime limit: the total amount we’ll pay for any eligible costs you incur during any time we cover you on any one or more plans with the same or equivalent benefits, even if there’s a break in your cover.

Medical advice: any medical opinion, medical recommendation or information given by a medical professional.

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 injury, illness or disease or signs or symptoms of injury, illness or disease.

Medically necessary: treatment that is prescribed by your medical practitioner, is in line with general advice, and in our reasonable opinion, is appropriate for your 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.

Medical provider network: all of the medical providers with whom we have contracted healthcare arrangements for members.

Member: a person we agree to cover under the plan and who is named on the Certificate of Insurance.

Member ID card: a physical or virtual card we issue for each member, which provides basic plan details and contact information.

Medical History Disregarded (MHD): we will cover your pre-existing medical conditions, subject to the benefits, terms and conditions of your plan.

Moratorium: a waiting period of 24 months from either your date of joining or the date shown in the special terms section of your Certificate of Insurance that must have passed before claims for any pre-existing medical conditions may become eligible under the plan. This includes the underwriting term CTT previously Moratorium.

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

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

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 you are not admitted for inpatient or daycare treatment.

Palliative treatment: any medical or surgical services aimed to relieve 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 you and who lives with you, but is not married to you.

Personal effects: personal belongings, including clothing worn and baggage owned by you, that you take with you on your trip.

Personal representative: an individual who has authority to act on your behalf in relation to your plan, as a result of an authorisation from you in writing, a power of attorney or a document evidencing that he or she is the executor of your estate.

Plan: our contract of insurance with you as contained in your plan documents.

Plan documents: the application, the Certificate of Insurance, this document and the Benefits Schedule.

Planholder: the person we have issued a plan to, named as planholder on the Certificate of Insurance.

Plan level: your Aetna Pioneer plan or add-on plan from the range available as shown on the relevant Certificate of Insurance.

Plan renewal date: the date when a new plan year is due to begin, as shown on your Certificate of Insurance.

Plan start date: the first day of the plan year, as shown on your Certificate of Insurance.

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

Preauthorised: any treatment, services or costs that we approve in writing following preauthorisation.

Pre-existing medical condition: any medical condition or related medical condition you have before the date of joining that has any one or more of the following characteristics:
- was foreseeable,
- clearly showed itself,
- you had signs or symptoms of,
- you asked for advice on,
- you received treatment for, or
- to the best of your knowledge, you were aware you had.
Premium: The amount you have to pay for your Aetna Pioneer plan.

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 medical 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 you receive after you have been in remission for more than five years.

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 we cover you under the plan during the plan year, as shown on your Certificate of Insurance.

Terminal: the end stages of a medical condition where in our reasonable opinion 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’s qualified and licensed in the country they provide treatment in.

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

Trip: any journey or period of travel that does not exceed the duration shown on your Aetna Travel plan Benefits Schedule. This includes the dates of departure from, and return to, your country of residence.

Underwriting: the process by which we assess risk and determine the appropriate cost of cover.

Visiting doctor: a medical practitioner or specialist who’s 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: the relevant insurer (acting through its administrator agent, details of which are available at www.aetnainternational.com/ai/en/about-us/legal/regional-entities), such insurer being the insurer which is permitted to carry on insurance business in your location under legal and regulatory requirements applicable to us, you and/or the plan at any given time (referred to as the relevant time for the purposes of this definition). This excludes, at any relevant time, any insurer which is not permitted to carry out insurance business in your location at that relevant time.

You: You as a member, or your personal representative.

17 Governing law, jurisdiction and language

The laws of Singapore govern your plan and any disputes or claims arising from or connected to them. The courts of Singapore shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with the plan, its subject matter or formation.

Translated versions of your plan documents are for information only. If there are any wording or interpretation disputes or discrepancies, the English versions will apply.

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

If we deviate from specific plan terms at any time, it won’t constitute a waiver of our right to comply with or enforce those terms at any other time. This includes the payment of premium or benefits.

18 Complaints

We strive to give you a first class service. If there’s an occasion when you feel we haven’t done this, we want to know.

Please contact us with your plan number, claim number (if applicable), contact details and as much detail as possible at: The Complaints Team Aetna Insurance Company Limited (Singapore Branch) 112 Robinson Road #09-01, Robinson 112 Singapore 068902 Telephone: +65-6593-8500 Email: AetnaInternationalComplaints&Appeals@aetna.com

We’ll deal with your complaint fairly, promptly and in accordance with relevant regulation. When we receive a complaint, we aim to resolve it by the end of the next business day. But if this isn’t possible, we’ll acknowledge your complaint by the end of the next business day and give you regular updates until we resolve the complaint. We’ll give our final response within eight weeks. If you’re not satisfied with the outcome of your complaint, you may be able to refer it 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.
Data protection

We’re committed to protecting your personal data and privacy. We’ll keep any personal information confidential and process it in accordance with the relevant legislation and guidelines, and our own strict internal policy.

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

Fraud

We may also use your information to detect and prevent fraud and will pass any false or inaccurate information on to other Aetna entities, agents or others so that they may do the same. They may pass information they hold about you to us so that we can do the same. We may also disclose your information if we’re required to do so by law enforcement or other legal agencies, governmental or judicial bodies, or to our regulators under proper authority.

Medical information

We’ll only disclose your medical information to those involved with your treatment or care, including your medical practitioner. If you ask us to, we’ll also send your medical information to any person or organisation responsible for meeting your treatment expenses, or their agents. We may discuss your information with your agent or broker if you’ve asked your broker to help handle your claims and you’ve authorised us to provide them with such medical information.

We won’t 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 writing. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose information to relatives, family members or other third parties.

Marketing

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. We’ll give you an opportunity to tell us if you don’t want to receive this information.

To help us make sure that your personal information remains accurate and up-to-date, please tell us about any changes when they happen.

You can ask to see the personal information we hold about you. There may be a charge for this.

Please write to:
The Data Protection Officer
Aetna Insurance Company Limited (Singapore Branch)
112 Robinson Road
#09-01, Robinson 112
Singapore 068902
Stay connected

Visit us
aetnainternational.com

Follow us
twitter.com/AetnaIntl

Like us
facebook.com/AetnaInternational

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Aetna does not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to www.AetnaInternational.com.

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.

Notice to United Kingdom residents: In the UK, Aetna Insurance Company Limited (FRN 458505) has issued and approved this communication.

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.