The details

For plans starting on or after
1 January 2021

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Before you join us

1 Introduction

Your plan documents detail what we do and don’t cover under your plan, as well as giving you important information about the terms and conditions of your plan. Please read this information carefully to make sure you’re completely satisfied with the cover we’re providing. If you have any questions, please contact us and we’ll be more than happy to help.

We don’t guarantee that your plan meets personal tax requirements and/or the visa and/or social health care requirements of the country you’re residing in. It’s your plan sponsor’s responsibility to ensure that any plan it chooses meets your needs.

If your area of cover is Area 1, you’re a citizen of the United States (US) and you spend more than 183 days in aggregate in the US in any one plan year, (i) we may cancel your cover, and (ii) you may be required to buy an ACA compliant plan or face US tax penalties.

If coverage provided by your plan violates or will violate any United States (US), United Nations (UN), United Kingdom (UK), European Union (EU) or other applicable economic trade sanctions, we reserve the right to consider economic trade sanctions, against the country where you or any of your dependants normally live, we reserve the right to:

• immediately end cover and stop paying claims under the plan (regardless of any permission you might have from any authority to continue cover), and /or
• declare your and your dependants’ membership on the plan as being void as if it never existed or cancel it at such other point as we deem appropriate.

In addition, funds (including, but not limited to, premiums and claims payments) may be blocked in accordance with applicable law.

For more information on OFAC, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

2 Material facts

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

If the plan sponsor does not tell us all material facts or gives us inaccurate or incomplete material facts, we can avoid the entire plan (treat it as if it had not existed) from the plan start date, plan renewal date or the date of any changes that were made to the plan if:

• we would not have issued, renewed or made changes to it, or
• we would only have done so on different terms, if we had known all of the material facts.

We will not avoid the entire plan if:

• the material facts only relate to a specific member or members,
• the plan sponsor had asked the member or members concerned about these material facts before applying for, renewing or making changes to the plan, and
• to the best of the plan sponsor’s knowledge or belief, the material facts they told us were accurate and complete.

We will only avoid the part of the plan which provides benefits to you if you, or the plan sponsor on your behalf:

• deliberately or recklessly gave us inaccurate or incomplete material facts, or
• did not take reasonable care to give us accurate and complete material facts and we would not have covered you under the plan at all had we known about such material facts.

We will not avoid the part of the plan which provides benefits to you if we would have provided cover to you on different terms under the plan had we known about the material facts, but we may refuse to pay all or part of any claim you make.

If we would have applied different terms, conditions and exclusions to you, then the plan will be treated as if it had contained the different terms, conditions and exclusions, and a claim will only be paid if:

• you have met all the terms and conditions of the plan and the claim is not otherwise excluded,
• you have met the different terms and conditions that we would have applied, and
• it does not fall within any different exclusions that we would have applied.

If we would have provided you with cover under the plan at a higher premium, the benefits payable on any claim you make will be reduced proportionately based on the amount of premium that we would have charged. For example, only half of each claim will be paid if we would have charged double the premium for you.
The plan sponsor must tell us immediately in writing about any change that affects information given in connection with the application for a plan, including information about you.

After we have been told about a change:

- We have the right to reassess your cover if it is a change to important information about you. We may apply new terms to you, or cancel your cover.
- We have the right to reassess the plan if the change to important information is about the plan sponsor or affects all or part of the plan. We may apply new terms to the plan, or cancel the plan.
- If there is a change in risk that the plan sponsor has not told us about, your cover may be cancelled, the plan may be cancelled, or any related claim may be reduced or rejected.

## 3 Eligibility

### Main member

To be eligible for the plan sponsor to add you as a main member to this plan, you must:

- be an employee of the plan sponsor, or if we agree, an employee of a company that is part of the same corporate group as the plan sponsor;
- be a certain level of seniority or be in a certain location that the plan sponsor has chosen and that we have agreed, if the plan sponsor does not want to include all employees on its plan;
- be aged 18-64 inclusive at your date of joining. If you're aged over 64 at your date of joining you may also be eligible; we will need to ask you some medical questions in order to decide if we can include you and on what terms; and
- not be a citizen of the US who resides in the US.

Your plan sponsor may add a main member to this plan within 30 days of the proposed main member meeting the above criteria. At any other time, we will need to ask the proposed main member questions in order to decide if we can include them and on what terms.

### Dependants

If a main member wishes to include a dependant on their plan, they must be the main member's:

- Spouse or partner;
- Unmarried child, stepchild or legally adopted child under the age of 18; or
- 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.

Your plan sponsor may add a dependant to your plan at any time. However, we may need to ask them some questions in order to decide if we can include them and on what terms if:

- you want to add them more than 30 days after the relevant main member's start date;
- for a child, you want to add them more than 30 days after their birth or legal adoption; or
- for a spouse or partner, they are aged over 64 at their proposed date of joining.

We'll apply the same benefits to main members and their dependants on your plan, subject to legal or regulatory requirements.

### Add-on plans

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

## 4 Joining the plan

Your plan sponsor must contact us to add a main member to this plan. We won’t be able to add the proposed main member until we receive all relevant information about them from the plan sponsor.

Your plan sponsor will tell the main member their future start date, which will also be shown on the main member’s Certificate of Insurance. We’re unable to backdate any cover.

We'll send the main member Member ID cards for each member. Note that we may charge you or the plan sponsor an administration fee to replace any plan documents or Member ID card. You can access your Certificate of Insurance and other plan documents through your Health Hub.

## 5 Plan benefits and currencies

The plan sponsor has chosen your plan level and benefits, including any add-on plans, details of which you can find in this Handbook, the relevant Benefits Schedule(s) and your Certificate of Insurance. Your Certificate of Insurance will also show any special terms applicable to you.

If your Benefits Schedule(s) shows more than one currency, the benefit limits shown in the same currency as your plan (set out in your Certificate of Insurance) will apply.

## 6 Pre-existing medical conditions

### Moratorium

If your Certificate of Insurance shows that your underwriting terms are moratorium or CTT previously MORI, this means your claim will not be paid if it’s relating to a pre-existing medical condition should one or more of the following have applied within the 24-month period before your date of joining (or the date shown in the special terms section of your Certificate of Insurance):
• it could be reasonably foreseen that the medical condition would occur after your start date,
• the condition clearly showed itself,
• you had signs or symptoms of the condition,
• you asked for advice about the condition,
• you received treatment for the condition, or
• to the best of your knowledge, you were aware you had the condition.

Once you’ve completed a continuous 24-month period after your date of joining we may cover your pre-existing medical condition 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 or CTT previously FMU, 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 during the application for your plan and your Certificate of Insurance doesn’t show an exclusion for that medical condition.

Medical History Disregarded
We will cover your pre-existing medical conditions, subject to the benefits, terms and conditions of your plan.

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, or
• using somebody else’s insurance to get treatment or services.

If you suspect fraud
Call our confidential Fraud and Investigation line immediately at +44-(0)1252-896-383 or email IGUKfraudgovernance@aetna.com.

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, regulatory bodies, legal agencies, and government departments to do this.

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,
• filling 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, and
• reporting suspected fraud to us.
While you’re with us

9 Adding dependants to your plan

Your plan sponsor must contact us to add each person who a main member wishes to include on their plan as a dependant (and who we agree meets the ‘dependant’ eligibility criteria described in this Handbook). We won’t be able to add them until we receive all relevant documents and information about them that we request.

Cover will start on the future date we agree with your plan sponsor. If on the date the plan sponsor contacts us to add a proposed member as a dependant, they’re less than 31 days old and we have covered one of their parents for a continuous period of at least 12 months, we’ll add them as a dependant to your plan with effect from their date of birth, regardless of their health. The plan sponsor and/or the main member will not need to complete an application form, and it is the plan sponsor’s responsibility to disclose to us any material circumstance that would influence our judgement as to whether to add the proposed member.

The terms of the main member’s plan will apply to the added dependant. Once we’ve accepted a proposed dependant, we’ll send the main member the new Member ID card and an updated Certificate of Insurance.

10 Removing a member

A main member should contact their plan sponsor in advance to request the removal of a dependant from your plan. We’ll remove the dependant on the future date the plan sponsor requests, and we’ll send the main member a revised Certificate of Insurance.

The plan sponsor can remove members from your plan at any time. We can remove you from your plan and notify your plan sponsor if:

• you no longer meet the eligibility criteria set out in the eligibility section of this Handbook,
• you, or any of your dependants, are directly or indirectly subject to any applicable economic trade sanctions, or
• you, any of your dependants or a representative acting on your or any of your dependants’ behalf submits a false or fraudulent claim.

If the plan sponsor, or we, remove a main member from the plan, we will also remove all of their dependants. The plan sponsor will let you know if they, or we, are planning to remove you and what your end date will be.

The plan sponsor is responsible for ensuring that the removed member deletes or destroys his or her Certificates of Insurance and Member ID cards on or by that member’s end date. If a member the plan sponsor has removed obtains treatment after that member’s end date that we’ve paid for, we have the right to recover the full amount of the claim from the plan sponsor or that member.

11 Notifying us of changes

You must tell your plan sponsor immediately in writing about any 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 your plan sponsor about a change, your plan sponsor should inform us and, depending on the nature of the change, we may:

• charge an 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.

12 Plan cancellation

Your plan sponsor will let you know if they are planning to cancel your plan and what your end date will be.

You won’t be able to make a claim for any costs incurred after the end date.

The plan sponsor is responsible for ensuring that all members delete or destroy his or her Certificates of Insurance and Member ID cards on or by that member’s end date. If a member obtains treatment after that member’s end date that we’ve paid for, we have the right to recover the full amount of the claim from the plan sponsor or that member.

13 Plan renewal

This plan is an annual contract. If your plan sponsor renews your plan we’ll send the main member the new plan documents and Member ID card which will apply from the plan renewal date.

If a main member’s child is no longer eligible as a dependant at the plan renewal date, that child can apply
for their own Aetna individual plan. As long as there is no break in their cover with us, we may continue the terms of their previous plan.

14 Claims

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

By telephone toll free on 0800-085-2596 or by landline on +44-203-788-3288.

By fax on +44-870-442-4377.

Or by e-mail at EuropeServices@aetna.com.

We may record calls for monitoring and training purposes.

If you don't 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're dialling from. When prompted during the call, please enter the access code 855-491-9150 and follow the instructions.

If you're calling from a country not included in the above link, then you can call collect or direct on +44-203-788-3288. To call collect you must contact the telephone operator in the country you're calling from and ask to link, then you'll have to pay the difference.

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 instead, you'll have to pay the difference.

What you need to know when claiming

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 can only pay claims to:

• you,

• your spouse, partner or child over the age of 18 if they are insured on your plan, or

• the provider.

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 you 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, or

• 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 the 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 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 medical provider 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, in your Benefits Schedule or on your Certificate of Insurance.

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. Complete one claim form for each medical condition. Send your claim form to us at EuropeServices@aetna.com along with scanned copies of any documents.
5. Or you can submit a claim online by completing the form and uploading scanned copies of any 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 preauthorization, 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.

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 plan) 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 your 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 prior written consent, you must not admit liability or fault to, or agree to a settlement with, such other party.

Fraudulent Claims

You, your dependants or any representative acting on your or any of your dependants’ behalf must not submit false or fraudulent claims. Any failure to comply will give us the right to take all appropriate measures in accordance with applicable laws which may include, but will not be limited to, the right to:

- declare your and your dependants’ membership on the plan as being void as if it never existed or cancel it at such other point as we deem appropriate,
- notify the plan sponsor in accordance with section 10 of this handbook,
- notify the relevant authorities and take further legal action against you as we deem appropriate,
- refuse to make payment either in whole or in part in respect of any false or fraudulent claim,
- seek to recover from you any payments we’ve already made in respect of the false or fraudulent claim in accordance with section 15 of this handbook, and / or
- immediately stop paying claims regardless of eligibility.

You acknowledge and agree that where we suspect that you or your dependants have submitted a false or fraudulent claim, we reserve the right to require that you or your dependants participate in such examinations, tests, check-ups or other medical investigations that we deem appropriate and to be carried out by a medical professional of our choice in order to establish whether a false or fraudulent claim has been submitted. We reserve the right to decline payment of claims until all such investigations have been concluded to our satisfaction.

15 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’ve already paid.

15.1 Acting against medical advice

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

15.2 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.

15.3 Administrative costs, fees and charges

- completing claims forms,
- completing or obtaining other documents
- administration fees and surcharges,
- any registration fees,
- overdue invoice charges, or
- shipping, delivery and custom fees.

15.4 Altered and amended documents

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

15.5 Brain and learning disorders, and speech and voice problems

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

15.6 Cosmetic treatment

Cosmetic treatment.

15.7 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.

15.8 False and fraudulent claims

False or fraudulent claims.

15.9 Gender reassignment

Costs directly or indirectly associated with gender reassignment.

15.10 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.
15.11 Illegal activities
You acting illegally or committing or helping to commit a criminal offence.

15.12 Active participant
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 at risk of contamination or injury.

15.13 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 evacuation if a local situation makes it impossible, dangerous or not practical to enter or leave a specific location or country.

15.14 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 and 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 and 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.

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

15.16 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 on non-medical grounds, 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.

15.17 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.

15.18 Sleep
Sleep apnoea, sleep-related breathing disorders, snoring and insomnia.

15.19 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 experimental or not clinically proven.
- 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,
sanitiser, gloves, masks, visors, thermometers, children’s food, baby supplies and infant formula given orally.

- A **medical professional** visiting you at home or in any non-clinical environment, unless you’ve requested preauthorisation and we’ve given our approval.
- 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.
- Treatment given, or referrals made, by a medical professional who is your spouse, partner, child, parent or sibling, or self-prescribed treatments or referrals if you’re a medical professional.
- Health education programmes and services including, but not limited to, family planning, antenatal classes and parenting classes.
- Nutritionist or dietitian consultations or services, unless you’ve requested preauthorisation and we’ve given our approval.

15.20 **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.

15.21 **Durable medical equipment**

Sight or hearing aids, furniture or any modifications to your personal or work environment.

15.22 **Medical evacuations 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.

15.23 **Mortal remains**

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

15.24 **Quarantine and isolation**

- unless it’s medically necessary for you to be protected from communicable diseases due to your medical condition, or
- in any non-clinical environment for any reason.

15.25 **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.

**Definitions**

Where we use bold words in your plan documents, they have the meaning set out below.

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 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.

**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.

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

**Aetna Summit plan**: the primary health care plan.

**Annual health assessment**: an age and gender-appropriate health review package to screen for the presence of medical conditions, where the screening is not required due to signs or symptoms, or in relation to a diagnosed medical condition. The package may include medical advice, physical examinations, and/or tests and diagnostic procedures.

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

**Assisted Conception:** a pregnancy that is conceived following fertility treatment, including pregnancies conceived through Intrauterine Insemination, In Vitro Fertilisation (IVF) or any other Assisted Reproductive Technology, and pregnancies conceived within one month of using fertility medication.

**Benefit:** the cover provided by your plan and shown in your Benefits Schedule, subject to any conditions or exclusions in this document 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.

**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.

**Communicable diseases:** medical conditions caused by the transmission of bacteria, viruses or other microorganisms.

**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.

**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:** when treatment is received following admission to a hospital bed or daycare unit, a medical professional discharges you after the treatment and you do not stay overnight.

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

**Dental:** that which affects the teeth and gums.

**Dental practitioner:** a person who:
- has attained primary degrees in dentistry and/or dental surgery by attending a dental and/or medical school recognised by a relevant accredited professional body, and
- is licensed by the relevant authority to practice dentistry and/or dental surgery in the country where the treatment is given.

**Dependant:** a person who we agree meets the ‘dependant’ eligibility criteria described in of the eligibility section of this Handbook and who we have added to your plan.
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.

Employee: a person who has entered into or works under a contract of employment (whether express or implied). This does not include (i) a person who has entered into a commercial arrangement to do or personally perform any work or services and where the circumstances do not give rise to an employment relationship; or (ii) a person who is self-employed but enters into contracts to perform work or services.

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 (FMU): the process we use to assess a member’s medical history and decide the special terms we offer them. Cover will still be governed by the benefits, terms and conditions of your plan with us.

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.

Group Member Application: the ‘Aetna Summit Group member application’ which you must complete, if we require it, and sign to agree to the terms of the plan, plus any supporting information.

Health Hub: a members’ online platform to find care, submit and track claims and view your plan details.

Home country: the country you’re from, as given on your Group Member Application or notified by you or the plan sponsor to us.

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

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.

Main member: a person who we agree meets the ‘main member’ eligibility criteria set out in the eligibility section of this Handbook and who we add to the plan.

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

Medical condition: any injury, illness or disease or signs or symptoms of injury, illness or disease.

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

Medically necessary: treatment that is prescribed by your medical practitioner, 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 health care arrangements for our members.

Member: a main member or dependant 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.

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 you can make claims for any pre-existing medical conditions under the plan.

Natural disaster: fire, flood, storm, earthquake, tidal wave, volcanic activity or avalanche.

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

Non-communicable diseases: medical conditions that are not communicable diseases.

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 the plan sponsor in relation to your Aetna Summit plan and any add-on plan(s) as contained in your plan documents, unless otherwise defined in your Benefits Schedule.

Plan documents: the Group Member Application (if applicable), the Certificate of Insurance, this Handbook, the Plan Sponsor Guide and the Benefits Schedule.

Plan level: the Aetna Summit plan or add-on plan that the plan sponsor has chosen from the range available.

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

Plan sponsor: the entity that purchases a plan for members.

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

Plan year: the period of cover from the plan start date to the day before the plan renewal date, as shown on 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 the plan sponsor has to pay for the Aetna Summit plan and any add-on plans.

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: age and gender-appropriate tests or diagnostic 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 being 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: Aetna Health Insurance Company of Europe DAC.

You: You as a member, or your personal representative.
17 Governing law, jurisdiction and language

The laws of the Republic of Ireland govern your plan, and any disputes or claims arising from or connected to them. The courts of the Republic of Ireland 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 premiums or benefits.

18 Complaints

We strive to give you a first class experience. If there’s ever a time 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 Global Benefits (UK) Limited
25 Templer Avenue
IQ Farnborough
Farnborough
Hampshire
GU14 6FE
United Kingdom
Telephone: +44 (0) 1252 745 910
Email: AetnaInternationalComplaints&Appeals@aetna.com

You can find full details of our complaints procedure at aetnainternational.com

We’ll consider 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. 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 offer 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 Financial Services and Pensions Ombudsman within six months of our final response. You can contact the Financial Services and Pensions Ombudsman using the details below:

Financial Services and Pensions Ombudsman FSPO
Lincoln House
Lincoln Place
Dublin 2
D01 VH20
Telephone: +353 1 5677 000
Email: info@fspo.ie
Website: www.fspo.ie

You can also contact the Financial Health Ombudsman for Northern Ireland using the details below:

Financial Health Ombudsman FHI
Suite 14, The Old Poultry
Leigh Street
Belfast
BT2 8GE
Telephone: 028 9096 7978
Email: fhi@nifsni.org.uk
Website: www.fhi.nifsni.org.uk

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administration, research, business associates, industry regulation, law enforcement, legal proceedings and public welfare.

In all situations other than those described above, we will ask for your written authorization before using or disclosing information about you. We will not send any personal data or health information outside the EEA unless the appropriate protections are in place, or unless there are emergency medical ground for doing so.

Personal data is sent to the United Kingdom for the purposes of plan and claims administration together with handling any complaints or data subject enquiries. Personal data sent to the United Kingdom is transferred on the basis of EU approved model contract clauses, which will be effective from the date the United Kingdom formally leaves the European Union.

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

You have the right to access to your personal information, to request correction, erasure, restriction of processing, transfer of your information, and object to the processing of your personal data.

If you would like to exercise any of your rights relating to your personal data, or enquiry any further information, please contact our designated Data Protection Officer: dpo@aetna.com

You can find our full terms and conditions and details of our privacy policy at www.aetnainternational.com/en/about-us/legal-notices.html

20 Areas of cover

This is the geographic area or areas of the world in which you must receive treatment or services for your plan to apply.

If you and/or your dependants are working, residing or spending time in sanctioned countries or regions, please let us know immediately. Sanctioned countries and regions currently include Crimea (annexed region of Ukraine), Cuba, Iran, North Korea and Syria. This list is subject to change based on changes in financial sanctions regulations. In addition, there are other countries subject to less broad sanctions than the countries/regions listed here. For more information, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Cover is subject to legal or regulatory requirements, depending on your nationality and country of residence.

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
- Israel
- Kiribati
- Macau
- Marshall Islands
- Micronesia, Federated States of Nauru
- New Caledonia
- Niue
- Norfolk Island
- Northern Mariana Islands

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

- China

Area 4
Includes the countries listed below and all countries and territories in Areas 5 and 6

- Australia
- Kuwait
- New Zealand
- Qatar
- Singapore
- United Arab Emirates

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

- Aland Islands
- Albania
- Andorra
- Anguilla
- Antigua & Barbuda
- Argentina
- Armenia
- Aruba
- Austria
- Azerbaijan
- Bahamas
- Barbados
- Belarus
- Belgium
- Belize
- Bermuda
- Bolivia
- Bonaire, Sint Eustatius & Saba
- Bosnia & Herzegovina
- Brazil
- Bulgaria
- Cayman Islands
- Channel Islands
- Chile
- Colombia
- Costa Rica
- Croatia
- Curaçao
- Cyprus
- Czech Republic

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We may modify our products, services, rates and fees, in response to legislation, regulation or requests of government authorities, these modifications may result in material changes to plan benefits.
Aetna® is a trademark of Aetna Inc. and is protected throughout the world by trademark registrations and treaties.

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. Your plan documents contain a description of benefits, exclusions, limitations and conditions of coverage. For more information, refer to www.AetnaInternational.com.

If coverage provided by this policy violates or will violate any United States (US), United Kingdom (UK), United Nations (UN), European Union (EU) or any other applicable economic and 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.

Aetna Health Insurance Company of Europe DAC insures your plan, is regulated by the Central Bank of Ireland ref: C47511, and has its registered address at Alexandra House, The Sweepstakes, Ballsbridge, Dublin 4, Republic of Ireland.

Important: This is a non-US (United States) 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.