Benefits Proposal for Health Aessentials (AHA)

Executive Summary

Aetna is privileged to present you with the enclosed proposal to cater to the healthcare needs of your employees.
We hope that it meets your requirements, and will be happy to work closely with you to provide the most suitable solution for your company and your employees.

This Benefits Proposal, together with the Financial Proposal, forms the complete proposal.

This Benefits Proposal includes the following sections:

Best regards

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Please read this carefully before you proceed with the document

Pages 3-4 Standard Plan Benefits
Read this for summary of standard benefits included in your proposal.
Then read **Financial Proposal 'Quote Summary'** for non-standard (upgrade/downgrade) plan benefits if chosen.

Note: Where benefit terms/limits are stated in the **Financial Proposal 'Quote Summary Page 1'**, they will supersede those stated in **Standard Plan Benefits**.

Pages 5-9 Master Benefits Schedule
Read this for full detailed descriptions of the benefits included in your proposal.
As this table includes all possible benefits under the plan, refer only to those benefits you see in the **Standard Plan Benefits** and your **Financial Proposal 'Quote Summary'**.

Pages 10-11 Exclusions

Page 12-15 Terms and Conditions
Read these for the exclusions and terms and conditions applicable on your plan.

Page 16-18 About Aetna
Read this for an overview of Aetna.

Standard Plan Benefits

Quote Validity	30 days
Plan Design	Structure of the AHA plan Step 1 : Choose Area Of Cover and Maximum Annual Aggregate Limit Step 2 : Choose Plan Design Plan 1 : Inpatient only Plan 2 : Inpatient + Outpatient only Plan 3 : Inpatient + Outpatient + Chronic Conditions Step 3 : Choose Co Pay / Annual Deductible Step 4 : Choose Upgrade Benefits
Area of Cover	There are 3 areas of cover: **SEA Area 1** : Asia & Pacific Rim including: Bangladesh, Bhutan, Brunei, Cambodia, Cook Islands, Fiji, India, Indonesia, Kiribati, Korea (South) Laos, Malaysia, Maldives, Marshall Islands, Federated States of Micronesia, Mongolia, Myanmar, Nauru, Nepal, Niue, Pakistan, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Sri Lanka, Thailand, Timor-Leste, Tonga, Tuvalu, Vanuatu and Vietnam. Excluded countries: Australia, Hong Kong, Japan, Macau, Mainland China, New Zealand, Singapore and Taiwan. **SEA Area 2** : **SEA Area 1** + Singapore Excluded countries: Australia, Hong Kong, Japan, Macau, Mainland China, New Zealand and Taiwan. **SEA Area 3** : Worldwide Excluding US Please refer to the Financial Proposal for the area quoted for.
Maximum Annual Aggregate Limit	Please refer to the Financial Proposal.
Policy Deductible (Annual Basis)	Please refer to the Financial Proposal.
Outpatient Co pay (Per Visit)	Standard : Nil unless stated on Financial Proposal
Benefit Terms	Per member per period of cover unless otherwise specified
Underwriting Basis	There are 2 types of underwriting basis: 1. Medical History Disregarded (MHD) : Most pre-existing exclusions and all wait periods are waived. 2. 2 year Moratorium Please refer to the Financial Proposal for the basis quoted for. <u>Note regarding 2 Year Moratorium basis</u> : a)Pre-existing conditions : Cover is not provided for any medical condition in existence on the date that the individual is accepted into the group (date of entry) until it has been treated such that the individual is symptom and advice free for 2 consecutive years following the date of entry with regard to that medical condition. This policy does not cover the treatment of pre-existing chronic conditions. b)Dental : 6 months wait period c)Pregnancy : 12 months wait period

Standard Plan Benefits

Inpatient, Day Patient, Emergency Care and Diagnostics	
Inpatient Care	Covered in full
Reconstructive Surgery	Covered in full
CT PET and MRI Scans	Covered in full
Organ Transplant	Covered in full
Parental Accommodation	Covered in full
Disease and Chronic Conditions Management	
Oncology	Covered in full
Renal Dialysis	Covered in full
Outpatient and Alternative Treatments	
Outpatient Surgery	Covered in full
Evacuation and Transportation	
Emergency Transportation	Covered in full
i) Evacuation	Covered in full
ii) Travel to & from medical appointments - member	Covered in full
iii) Travel to & from hospital visits - escort	Covered in full
iv) Economy air tickets for return of member & escort	Covered in full
v) Non-hospital accommodation pre-& post-hospital admission	Up to $200 per day, and $6,250 per evacuation
Accident and Emergency Treatment outside Area of Cover	IP Treatment: Up to $62,500 per medical condition
	Out-Patient Treatment : Up to $625 ($100 excess) per medical condition

Appendix: Master Benefits Schedule

Annual Limit
Maximum annual aggregate limit **We** will provide **cover** for the **treatment** of **medical conditions** that first occur during any **period of cover** and where **treatment** is actually given during the current **period of cover** or where such **medical conditions** have occurred prior to the **date of entry** but have been declared to and accepted by **us** in writing, or where the **policyholder** has purchased Medical History Disregarded. All costs incurred must be **medically necessary** and subject to **reasonable and customary charges,** based on the average **treatment** costs applicable to the region in which the **treatment** was received, as determined by **us**. **Inpatient** accommodation costs are for a standard **private room** unless the **plan sponsor** has opted to apply an alternative bed limit.
Area of cover The **regional area** or specific country in which the member must be located/resident to receive eligible **treatment** as stated in the benefits schedule and **certificate of insurance**. **Elective treatment**, **emergency treatment** and **evacuations** outside the **area of cover** are excluded.
STANDARD BENEFITS : Inpatient, Day Patient, Emergency Care and Diagnostics
Inpatient care Charges incurred for the **treatment** of a **medical condition**, including stabilisation of an **acute chronic** condition, when **treatment** is received as an **inpatient** or **day patient** including: i) Accommodation and associated charges. ii) Admittance to the intensive care unit. iii) Charges for nursing by a **qualified nurse** and theatre fees. iv) **Medical practitioner** fees including consultations, **specialist** fees and Anaesthetist fees. v) Diagnostic and surgical procedures including pathology and X-rays. vi) Reconstructive surgery (including **outpatient treatment**) to restore natural function or appearance required as a result of an **accident** or illness occurring during the **period of cover** and where **treatment** takes place within 12 months of the insured event occurring. vii) **Drugs and dressings**, medicines and appliances prescribed by a **medical practitioner** or **specialist**, including Traditional Chinese Medicine. viii) **Rehabilitation** (including **outpatient treatment**) in a recognised **rehabilitation** unit of a **hospital** subsequent to **inpatient treatment** lasting 3 days or more, which takes place within 14 days of discharge. **Treatment** must be recommended and under the direct control of a **specialist**. **Treatment** includes the use of special **treatment** rooms, physical and/or speech therapy fees, and other services usually given by a **rehabilitation** unit. ix) **Outpatient treatment** connected with **inpatient treatment** will be covered for 60 days pre- and post-**hospital admission**.
CT, PET and MRI scans Scans received as an **inpatient, day patient or outpatient**. This must be pre-authorised by us.
Organ transplant The organ transplants covered under this **policy** are as follows: heart, heart/lung, lung, kidney, kidney/pancreas, liver, allogenic bone marrow and autologous bone marrow.
Parental Accommodation **Hospital** accommodation costs of a parent or legal guardian staying with a **member** who is under 18 years of age and is admitted to **hospital** as an **inpatient**. The **newborn** must be enrolled as a **member** within 30 days after birth in order to be eligible for any **benefits** (as per **Policy** terms).
New Born Care **Inpatient treatment** of an **acute medical condition** being suffered by a **new born** baby that occurs within 30 days following birth. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births, are excluded from this **benefit**. In circumstances where a **congenital anomaly** occurs in a **new born** baby, **cover** will be excluded under this **benefit** and payable under the **benefit** for **congenital anomalies**. Following the 30 day **new born benefit** period, excepting any **medical conditions** occurring or manifesting themselves during the 30 day period immediately following birth, the **member's dependant** will be eligible for **cover** subject to written notification within 30 days of birth and all premiums being paid in full within 30 days of the due date. A declaration of health is required with respect to all **dependants** who are born following infertility **treatment** (assisted conception). The **newborn** must be enrolled as a **member** within 30 days after birth in order to be eligible for any **benefits** (as per **Policy** terms).
OPTIONAL BENEFITS : Inpatient, Day Patient, Emergency Care and Diagnostics
Inpatient psychiatric treatment **Treatment** received in a registered psychiatric unit of a **hospital**. All **benefits** are conditional on pre-authorisation from **us** and all **treatment** being administered under the control of a registered psychiatrist. Without **our** written confirmation prior to such **treatment**, **we** will not be liable to pay any **benefit**. However, the initial consultation with the **medical practitioner** (not a psychiatric **specialist**) that results in a psychiatric referral is covered without the requirement for pre-authorisation.

Accidental damage to teeth

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

Complications of pregnancy

Treatment of a **medical condition** arising during the antenatal stages of pregnancy, a **medical condition** arising during childbirth and that requires a recognised obstetric procedure, and post natal checkups required as a result of the complication of pregnancy for up to six weeks. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births are excluded from this **benefit**.

This **benefit** is payable after the first 12 months from the **commencement date** or **date of entry**, whichever is the later.

STANDARD BENEFITS : Disease and Chronic Conditions Management

Oncology

All **medically necessary treatment** received for, or related to, the diagnosis of cancer when received as an **inpatient**, **day patient** or **outpatient** including **palliative treatment.**

Renal Dialysis

Chronic supportive treatment of renal failure or Renal Dialysis incurred immediately pre- and postoperatively or incurred in connection with acute secondary failure when dialysis is part of intensive care.

OPTIONAL BENEFITS : Disease and Chronic Conditions Management

Chronic conditions

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

Congenital anomalies

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

Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

The following benefits are covered:

i) **Medically necessary** durable medical equipment prescribed by a treating **specialist**, which is necessary to deliver or facilitate the delivery of prescribed **drugs and dressings**. This includes, but is not limited to, diabetic monitoring equipment.

ii) Ancillary charges following **treatment** as an **inpatient** or **day patient** including the purchase or rental of crutches, and costs associated with the initial purchase or rental of a wheelchair.

iii) External prosthetics required following surgery; including braces and callipers, artificial eyes and the initial purchase and fitment of an artificial limb.

iv) Orthotic supplies including insoles and orthotic supports.

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

AIDS

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

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

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

STANDARD BENEFITS : Outpatient and Alternative Treatments

Outpatient surgery

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

OPTIONAL BENEFITS : Outpatient and Alternative Treatments

Outpatient care

All **direct settlement outpatient treatment** over USD$100 requires pre-authorisation (this does not apply if you select the "covered in full" **outpatient** care **benefit**).

Medical practitioner, **specialist**, consultant and nursing fees and **outpatient** charges including diagnostic and surgical procedures including pathology, x-rays, **drugs and dressings** and **appliances** prescribed by a **medical practitioner** or **specialist**. Physiotherapy on referral by a **medical practitioner** is restricted to 10 sessions per **medical condition**, after which it must be further reviewed by a **specialist**. A medical report will be required for

outpatient physiotherapy after 10 sessions. A referral letter/report must be submitted with the first claim for such **treatment**.

Alternative treatment

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

Vaccinations and inoculations

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

Home nursing

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

This must be pre-authorised by **us**.

STANDARD BENEFITS : Evacuation and Transportation

Emergency transportation

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

This **benefit** does not include the cost of car hire.

Evacuation and additional travel expenses (within the area of cover)

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

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

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

i) **Evacuation** costs including the costs of one other person to travel with the **member** as an escort, if **medically necessary**.

ii) Travel to and from medical appointments when **treatment** is being received as a **day patient**.

iii) For an accompanying person to travel to and from the **hospital** to visit the **member** following admission as an **inpatient**.

iv) Economy class airline tickets to return the **member** and the escort to the **country of residence** or to the country where **evacuation** occurred.

v) Non-**hospital** accommodation for the **member** and escort for immediate pre- and post-**hospital** admission periods provided that the **member** is under the care of a **specialist**.

Accident & emergency treatment outside area of cover

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

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

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

When this **benefit** is purchased on a "covered in full" basis, **evacuations** are available as defined under "Evacuation & Additional Travel Expense" on a worldwide basis.

COPAYS/DEDUCTIBLES

Choose an annual deductible

If selected, **direct settlement** for **outpatient treatment** is not available.

Pay an outpatient copay per visit

Outpatient consultations are subject to a **copay per visit**. If a claim is submitted by the **member** for reimbursement, the **copay per visit** will be deducted before reimbursement.

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

i) Complications of pregnancy

ii) Congenital anomalies

iii) CT and MRI scans

iv) Oncology

v) **Outpatient** care

vi) **Outpatient** surgery

Apply an inpatient bed limit

Inpatient bed costs are restricted to the selected **inpatient** limit, and corresponding room type (Private or Semi Private) unless in respect of HDU and ITU admissions, which remain fully covered.

UPGRADE BENEFITS

Mortal remains

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

Necessary burial or cremation fees including:

- The cost of reopening a grave and burial costs, or
- The cost of opening a new grave and burial costs, including any exclusive right of burial fee, or
- In the case of cremation:

1. The cremation fee
2. The cost of any doctor's certificates
3. The cost of removing a pacemaker or other medical device which must be removed before the cremation

Out of country transportation (within the area of cover)

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

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

Non-**hospital** accommodation for the **member** and escort for immediate pre- and post-**hospital** admission periods provided that the **member** is under the care of a **specialist**.

Alternative cash benefit for hospitalization

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

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

If an **annual deductible** is selected it shall not apply to this **benefit**.

Traditional Chinese or Ayurvedic medicine

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

Dental – routine dental treatment

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

- examinations
- tooth cleaning
- normal compound fillings
- simple non-surgical extractions

This **benefit** excludes orthodontic **treatment**, restorative **treatment** and dental implants.

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

Dental – combined routine and restorative dental

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

- examinations
- tooth cleaning
- normal compound fillings
- simple non-surgical extractions

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

- removal of impacted, buried or unerupted teeth
- removal of roots
- removal of solid odontomes

- apicectomy
- new or repair of bridge work
- new or repair of crowns
- root canal **treatment**
- and new or repair of upper or lower dentures
- removal of wisdom teeth (whether performed in **hospital** or in dental surgery, whether performed by a **dental practitioner**, **specialist**, or an oral or maxillofacial surgeon)

This **benefit** excludes orthodontic treatment and dental implants.

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

Wellness

This **benefit** covers the cost of:

- Bilateral mammogram/breast examination and routine gynaecological tests including PAP tests
- Testicular/prostate examination/PSA/DRE tests
- Routine medical checkups and associated tests, such as: blood and cholesterol checks, height/weight body mass index, resting blood pressure, urine analysis, cardiac examination, exercise electrocardiogram (ECG), other vital organ function tests and chest x-ray

Hearing benefit

The cost of one annual hearing test and hearing aids.

Vision care

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

Wellness, vision and hearing

This **benefit** covers the cost of:

- Bilateral mammogram/breast examination and routine gynaecological tests including PAP tests
- Testicular/prostate examination/PSA/DRE tests
- Routine medical checkups and associated tests, such as: blood and cholesterol checks, height/weight body mass index, resting blood pressure, urine analysis, cardiac examination, exercise electrocardiogram (ECG), other vital organ function tests and chest x-ray
- The cost of one annual hearing test and hearing aids.
- The cost of one routine eye exam per **period of cover** and the purchase of vision hardware, when the member's prescription has changed. Vision hardware covers prescribed glasses or contact lenses.

Mother and baby

i) Routine pregnancy

Costs associated with normal pregnancy and childbirth, including normal deliveries as a result of infertility **treatment** (assisted conception), voluntary caesarean section costs and **medically necessary** caesarean costs due to any non-medical previous caesarean sections. This **benefit** covers the cost of pre- and post-natal checkups for up to six weeks, prescribed pre natal vitamins and delivery costs, including costs associated with qualified midwives, when associated with delivery.

All costs relating to complications of pregnancy or childbirth following infertility **treatment** (assisted conception) will be limited to this **benefit**. This **benefit** extends to include routine neo natal care and **new born** packages (including elective circumcision) for the first 24 hours following birth, when the baby is accompanying its mother whilst she is receiving **treatment** as an **inpatient** in a **hospital** (mother being an insured **member**).

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

A 12 month wait period applies from the purchase date of this **benefit** or the **member's date of entry**, whichever is the later.

ii) New born accommodation (Covered in full)

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

iii) Well-baby care (Up to $625)

Well-baby checks, effective from 24 hours after birth and up until the child's second birthday & as recommended by a **medical practitioner** or **specialist**. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as **hereditary** and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, hemoglobin and other blood tests, including tests to screen for sickle hemoglobinopathy.

Exclusions

1. Any medical condition or related condition for which you have received treatment, had symptoms of, and to the best of your knowledge existed or you sought advice for prior to your date of entry (pre-existing medical condition), except where such medical conditions have been declared to us and accepted in writing. After two years of continuous membership, any pre-existing medical conditions (and related conditions), with the exception of congenital conditions, will become eligible for benefit provided (in respect of that condition) that you have not during that period:
i) Consulted any medical practitioner or specialist for treatment or advice (including checkups).
ii) Experienced further symptoms.
iii) Taken medication (including drugs, medicines, special diets or injections).
This does not apply if the plan is on MHD basis.

2. Chronic supportive treatment of renal failure, including dialysis unless the Chronic Conditions benefit is part of your plan or has been purchased. We will, however, pay for the cost of renal dialysis incurred:
i) Immediately pre- and post-operatively.
ii) In connection with acute secondary failure when dialysis is part of intensive care.

3. Treatment, which we determine on general advice, is either experimental or unproven.

4. Congenital anomalies where symptoms exist or where advice has been sought prior to the member's date of entry unless the member is an infant up to the age of 12 months (even if it is on MHD basis). This exclusion is removed if the benefit for congenital anomalies including pre-existing conditions has been purchased.

5. Preventive medicines, and routine tests and physical examinations by a medical practitioner, including gynaecological investigations, unless the Wellness benefit or Wellness Preventive Screening benefit has been purchased. Normal hearing tests are excluded unless the Hearing benefit or Wellness Hearing and Vision module has been purchased.

6. Non-medical/natural degenerative eye defects, including but not limited to, myopia, presbyopia and astigmatism and any corrective surgery for non-medical/natural degenerative sight defects. Normal eye tests are excluded unless the Vision Care benefit has been purchased.

7. Rehabilitation except as expressly provided under the benefit for Inpatient Care, Rehabilitation.

8. Treatment received in health hydos, nature cure clinics, spas, or similar establishments. Services such as massages, hydrotherapy, reiki, or other non-medical treatments. Treatment given at establishments or a hospital where that facility has become the member's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

9. Cosmetic treatment, and any consequence thereof.

10. Any treatment for weight loss or weight problems including but not limited to bariatric procedures, diet pills or supplements, health club memberships, diet programs and treatment in a residential treatment facility for eating disorders. Any complications arising from weight loss or other excluded procedures are not covered.

11. Alternative therapy, including, but not limited to, hypnotherapists and lactation examiners.

12. Costs incurred in connection with locating a replacement organ or any costs incurred for removal of the organ from the donor, transportation costs of same and all associated administration costs.

13. Voluntary caesarean section costs or medically necessary caesarean section costs due to any previous voluntary caesarean sections undertaken, unless the benefit for Routine Maternity has been purchased.

14. Pregnancy terminations on non-medical grounds, antenatal classes or midwifery costs when not associated with delivery.

15. New born neo-natal care costs are excluded unless the benefit for Routine Pregnancy has been purchased, which provides cover for the first 24 hours following birth, whilst the mother (being and insured member) receives treatment as an inpatient.

16. Treatment directly or indirectly arising from (or required in connection with) male and female birth control, sterilization (or its reversal). Infertility treatment (assisted conception) is excluded unless the benefit for infertility treatment has been purchased. Any complications of pregnancy and routine pregnancy costs resulting from infertility treatment (assisted conception) are excluded except

where the benefit for Routine Pregnancy has been purchased. Where this has been purchased, complications of pregnancy and Routine Pregnancy costs resulting from infertility treatment (assisted conception) will be limited to the amount of your selected Routine Pregnancy benefit.

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

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

19. Venereal disease or any other sexually transmitted diseases or any related condition except for those payable under the AIDS benefit.

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

21. Treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy and developmental, social or behavioural problems in children (except as covered under the Wellness benefit).

22. Treatment for alcoholism, drug or substance abuse or any addictive condition of any kind and any injury or illness arising directly or indirectly from such abuse or addiction. For members residing in the Czech Republic, we cover the cost of treatment for accidents resulting from the consumption of drugs or alcohol in line with minimum health requirements provided that no illegal acts have taken place.

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

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

25. Costs and expenses incurred where a member has travelled against medical advice.

26. Evacuation expenses (unless pre-authorised by us). Air rescue, sea rescue or mountain rescue costs (unless incurred at recognised ski or similar winter sports resorts).

27. Travel and accommodation costs unless specifically agreed by us in writing prior to travel. No travel and accommodation costs are payable where treatment is obtained solely as an outpatient, including the costs of a hired car.

28. Treatment for sleep related breathing disorders, including snoring, fatigue, jet lag or work-related stress or any related condition.

29. Dietary supplements and substances that are available naturally and that can be purchased without prescription, including, but not limited to, vitamins, minerals , organic substances, and infant formula given orally. We will however pay for prescribed pre natal vitamins under the Routine Pregnancy benefit if purchased.

30. Home visits by a medical practitioner, specialist or qualified nurse unless specifically agreed by us in writing prior to consultation.

31. Complications of pregnancy costs arising during the first 12 months from the commencement date or date of entry, whichever is the later unless underwriting is on MHD Basis or the benefit for Complications of Pregnancy with no wait period has been purchased.

32. External prostheses, including their maintenance or fitting, any hearing aids or other equipment, medical or otherwise except as is specified in the benefit for Durable Medical Equipment Prosthetic and Orthotic Supplies (DMEPOS), and the Hearing or Vision benefits if purchased.

33. The following hazardous activities are excluded: playing professional sports and/or taking part in motor sports of any kind; mountaineering, including potholing, spelunking or caving; high-altitude trekking over 2,500 metres; skiing off-piste or any other winter sports activity carried out off-piste; and arctic or antarctic expeditions.

34. Treatment for complications arising from any uncovered and/or excluded procedures or treatments.

35. Self-treatment, or treatment provided by a Direct Family Member. This includes but is not limited to prescribed medication, diagnostic tests and surgical procedures.

36. All benefits are excluded unless they appear on your benefits schedule.

Terms & Conditions

1. This proposal, its terms and conditions are based on the information submitted to Aetna for quotation purposes. It is important to note that any deviation or amendments to these terms and conditions will invalidate this proposal and revised terms will be issued.

2. Aetna reserves the right to modify its products, services, rates, fees, and where appropriate the application of local taxes in response to legislation, regulation or requests of government authorities which result in material changes. This proposal does not constitute a contract of insurance, and the statements in this proposal are not intended as legal representations or warranties. Our obligation to one another will be limited to the terms of the Group Policy.

3. This proposal is valid up to and including the date stated in our quotation. After that date, we reserve the right to amend our proposal terms and conditions, and rate summary.

4. The billing premium is subject to the provision of a final census for administration purposes.

5. All material facts (e.g. were applicable, pre-existing health conditions, involvement in hazardous activities, and claimants over 10,000 USD) that may affect our assessment and consideration of an application should be declared. Failure to declare such material facts may invalidate cover under a group plan. If you are in doubt whether a fact is material then it should be disclosed.

6. We reserve the right to amend our quotation terms and conditions if any of the following occur:
i) If the final membership changes from the census provided for quotation purposes.
ii) If complete member Nationality and Location data is not provided at the time of quotation. This quotation is only indicative if this data is not available at the time of quotation. Prior to the commencement date of the Group Policy, member Nationality and Location must be provided for all members.

7. This proposal is based on a Group Policy for eligible Employees and Dependents. All members are subject to the eligibility terms and conditions of the policy. Cover is only provided for group members (& eligible dependents) where declared & accepted by Aetna.

8. Group eligibility
i) A group needs a minimum of 3 employees and can only be made up of employees of the same company.
ii) For a group that consists solely of members of the same family, it must be fully substantiated by the employer that such members are all working for the same employer.
iii) Where husband and wife are both employed by the same company, they are deemed to be one employee and eligible dependents.
iv) Eligibility is on an Employer Paid basis, meaning that the employer determines which members are to be covered, and pays the premium for all members. This proposal assumes there is no voluntary enrolment to this plan for all Employees and Dependents.
v) Employees and dependents need to be in the same country. Where it differs, the country of higher category will be applied to the whole family.

9. This proposal is based on our standard International Policy Terms and Conditions. For a comprehensive list of the Policy Terms and Conditions please refer to the Policy Summary, Member Handbook and Certificate of Insurance (where issued).

10. The Policy is an Annual Contract, unless otherwise stated.

11. Premiums must be received before the policy commencement date.

12. This proposal is subject to underwriting approval and has been provided on the basis stated in this proposal. Aetna reserves the right to review the Underwriting basis on the provision of any material facts which could change our view of the risk. Please refer to the Pre-sale documentation for Medical Underwriting terms.

13. Policy
The insurance contract consists of the policy (group policy); the group formation form or other application form; the current rates on file with the policyholder; and the policy documentation, including the certificate of insurance, benefits schedule and member handbook. The rights of the policyholder; any insured employee; or any beneficiary will not be affected by any provision other than the one described above.

14. Language
The policy may only be completed in English.

15. Eligibility for Cover

New applicants will be eligible for cover up until the age of 65. Any employee or dependant not enrolled within 30 days of eligibility will be subject to individual underwriting. New born children will be accepted for cover (subject to the limitations of the new born benefit) from birth. Acceptance of new born babies is subject to written notification within 30 days of birth and receipt of the full premium within a further 30 days following notification. Children who are not more than 18 years old residing with the employee, or 26 years old if in full-time education, at the date of entry or at any subsequent renewal date, will be accepted for cover as your dependants. Children will not be accepted for cover, unless on a policy with a legal parent or guardian and subject to the identical benefits applying to all parties. A declaration of health is required with respect to all dependants who are born following assisted conception. We reserve the right to reject any application without giving any reason.

16. Termination of Cover
Cover may end if:
i) Your employer cancels or terminates the group plan.
ii) You voluntarily stop your cover under the group plan.
iii) You are no longer eligible for cover (e.g., your employment stops.)
iv) You exhaust the maximum annual aggregate benefit under the group plan.
v) You fail to reimburse us within 14 days of receipt of notice that we have made payment for treatment of a medical condition not covered within the terms and conditions of the group plan.

17. Cover
We will pay the insurance benefits (specific benefits will not exceed the corresponding payment limit and the total amount of benefits will not exceed the mutually agreed maximum insured amount of the policy) as follows: all costs incurred must be medical necessary and subject to reasonable and customary charges. The insurance contract will provide cover for treatment given during the current period of cover.

18. Period of Cover
Your plan is in force for the period of cover noted in your certificate of insurance. The period of cover is annually renewable thereafter.

19. Policy Documents
We will provide a certificate of insurance for each member and any eligible dependants benefitting from cover under the policy.

20. Contribution
If you, or any dependant named on your policy, are entitled to claim from any other insurance policy for any of the costs, charges or fees for which you are insured under the contract, you must disclose the same to Us and We shall not be liable to pay or contribute more than our rateable proportion.

21. Change of Risk
The policyholder or insured person must inform us as soon as reasonably possible of any material changes that affects information given in connection with the application for cover under the policy. We reserve the right to alter the policy terms or cancel cover for an insured person following a change of risk.

22. Declaration of Material Facts
All material facts (e.g., a pre-existing health condition or involvement in a hazardous activity) that may affect our assessment and consideration of an application should be declared. Failure to do so may invalidate your cover under a group plan. If you are in doubt whether a fact is material then it should be disclosed.

23. Break in Cover
Where there is a break in cover, for whatever reason, we reserve the right to reapply exclusion clause 1 in respect of pre-existing medical conditions.

24. Claim Notification
Please ensure that your claim form is completed in full and returned within 180 days of the date of treatment. Refer to the claims section on page 12 for more detail.

25. Payment of Claims
If we think that the evidence of the claim submission and the information provided is incomplete, then you will be informed promptly of the required supplementary information. Providing all relevant information is submitted to support your claim, we will reimburse you by the payment method of your choice as stated on your claim from.

26. Fraudulent or Unfounded Claims

If any claim is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable. In addition, all cover in respect of the insured persons shall be cancelled void from the date of entry.

27. Applicable Law
The law applicable to this policy shall be specified in the certificate of insurance. If no law is specified, then the policy shall be construed according to the laws of Singapore, and shall be subject to the non–exclusive jurisdiction of the courts of Singapore.

28. Subrogation
The policy shall be subrogated to all rights of recovery that insured persons have against any other party with respect to any payment made by that party to insured persons due to any injury, illness or medical condition insured persons sustain to the full extent of the benefits provided or to be provided by the policy. If insured persons receive any payment from any other party or from any other insurance cover as a result of an injury, illness or medical condition, we have the right to recover from, and be reimbursed by them, for all amounts we have paid and will pay as a result of that injury, illness or medical condition, from such payment, up to and including the full amount received. We shall be entitled to full reimbursement from any other party's payments, even if such payment will result in a recovery that is insufficient to fully compensate the insured person in part or in whole for the damages sustained. Insured person's are required to fully cooperate with us in our efforts to recover any payments made including any legal proceedings that we may conduct and proceed with on their behalf at our sole discretion. Insured person's are required to notify us within 30 days of the date when any notice is given to any party, including an insurance company or lawyer, of the insured person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or medical condition sustained by the insured person. Other than with our written consent, insured person's have no entitlement to admit liability for any eventuality or give promise of any undertaking that is binding upon them. In the event that any claim or dispute is made in respect of this subrogation or any part thereof, including, but not limited to, any right of recovery provision which is ambiguous or questions arise concerning the meaning or intent of any of its terms, we shall for the avoidance of doubt have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

29. Family/Dependant Cover
Employees and their dependants are required to be covered under the same group plan with identical benefits.

30. Membership Applications
We maintain the right to ask the plan sponsor to provide proof of age and/or a declaration of health of any person included in his/her application. We reserve the right to apply additional options, exclusions or premium increases to reflect any circumstances the plan sponsor or insured person advises in their application form or declares to us as a material fact.

31. Medical Evaluation
We reserve the right to request further tests and or evaluation where we have decided that a condition being claimed for may be directly or indirectly related to an excluded condition.

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

33. Our Right of Cancellation
In the event of any non-payment of premium by the policyholder, we shall be entitled to cancel the policy and any related cover/plan. We may, at our discretion, reinstate cover if the full premium is subsequently paid, though terms of cover may be subject to variation. We may at any time terminate a member's cover if he/she or the policyholder has at any time:
i) Misled us by misstatement
ii) Knowingly claimed benefits for any purpose other than as are provided for under this policy
iii) Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to our detriment
v) Otherwise failed to observe the terms and conditions of this policy or failed to act with good faith.

34. Liability
Our liability shall cease immediately upon termination of the policy for whatever reason, including without limitation non-renewal and non-payment of premium.

35. Parties to the Contract
The only parties to the contract are the policyholder and us.

36. Currency

The monetary limits applicable to this policy will be expressed in the same currency as the insurance premium. Claims paid in a local currency will be converted at the rate of exchange quoted on www.oanda.com at the date the insured person received treatment.

37. Conflict or Civil Unrest, Chemical or Radioactivity Contamination

Treatment and expenses directly or indirectly arising from or required as a consequence of conflict or civil unrest, chemical or radioactivity contamination from any chemical and nuclear material or from the combustion of nuclear fuel or any related condition are covered by the policy provided the member:

i) Is not an active participant in any conflict or civil unrest

ii) Is not involved in any illegal activities which directly or indirectly lead to injury or illness

iii) Does not knowingly enter or remain in a country, region or location where there is conflict, civil unrest, natural disaster, chemical, nuclear or radioactive contamination

iv) Does not intentionally put him/herself at risk of illness or injury resulting from conflict, civil unrest, natural disaster, chemical, nuclear or radioactive contamination

v) Is not a member of any armed forces, security services including personal protection, chemical, nuclear or radioactive contamination cleaning crews of any kind or type (including governmental workers or private teams) Based on the information provided at inception or renewal Aetna will assess the current, future or developing risk exposure of members located in high risk areas and will notify the policyholder of any actions, limitations, exclusions or premium loadings required to ensure on going cover and member safety.

38. Your Rights of Termination

The policy may be terminated by the policyholder, as to all or any class of its members, by notifying us in writing within 14 business days from the date the policyholder receive the policy document and, provided no claims have been made, we will arrange a full refund of any premiums paid. The policy document is deemed to have been received by the policyholder within 3 days after we have dispatched it. Otherwise, the policy, or any cover included, may only be terminated by the policyholder, as to all or any class of its members, with effect from the renewal date. We must be given written notice of intent to non-renew within 15 days of your renewal date. If the policy is terminated by the policyholder at any other time, whatsoever the reason, there will be no return of premium.

39. Policy Owners' Protection Scheme – Disclosure Statement

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

40. Errors and Omissions Excepted.

About Aetna

World-class benefits solutions backed by strength and stability.

We are delighted to have the opportunity to outline the ways in which Aetna can serve you and your employees. Our history of more than 155 years of experience and nearly 40 years of international experience is what sets us apart. We use our unparalleled depth of health care knowledge and practice to design benefits solutions that work for you.

As one of the largest and most prominent international health benefits providers, we support more than 445,000 international members. And with local teams around the world, we understand how to customise programmes based on individual country requirements to offer relevant solutions for expatriates, third-country nationals and local nationals.

Here are some of the advantages Aetna offers:

- A **global presence** that covers all areas of the world and allows us to deliver global solutions with a local touch.
- A **broad range of products and services** that are flexible enough meet the needs of all types of employees.
- A **first-class service model** offering 24/7 service through worldwide service centres and clinical support.
- A **focus on health and quality of care** that helps members reach and maintain their optimal state of health.

Our Global Presence

Our global presence includes on-the-ground operations throughout the United States, Europe, Asia, Africa, and the Middle East. Aetna International has over 700 employees worldwide, almost half of whom live and work outside of the United States. We also deploy our U.S.-based employees on assignment to different locations throughout the world. Because we have local teams throughout the world, we are able to gain unique and powerful insights into how to best customise solutions based on individual country requirements.

Aetna International is driven by core values of Innovation, Integration, Flexibility and First-Class Service — all of which support Aetna's core values, and collectively create an unprecedented global brand.

Our Products and Services

Innovation: Keeping You and Your Employees Connected

Aetna is committed to providing you and your employees with tools that ease the health care process throughout all stages of an international assignment. Our global website includes a secure site that offers you and your employees access to:

- Password-protected member and plan sponsor websites
- Personalised member benefits information through Aetna Navigator®
- International doctor and hospital search tools
- Quick answers to benefit questions
- Claim forms and filing instructions
- Health, travel and news articles
- Translation databases for medications and medical terms
- Global security information
- Access to direct-settlement hospital arrangements
- Access to view relevant member materials and forms
- Customisable tools including a currency converter and world clock

In addition, we have multilingual capabilities across our public pages that provide content in six languages.

First-Class Service

We continually challenge ourselves to take the service we provide to the next level. As part of this advanced-service model, we are dedicated to being a partner who provides consultative solutions, applying a first-class level of service philosophy to all of our touch points.

Aetna International Service Centre

Aetna offers global claims processing and dedicated member service from international service centres. These centres are staffed by dedicated global claims processing and member service professionals, who are available 24/7 via toll-free telephone, fax and e-mail to assist members with questions regarding claims, benefits and eligibility. Our multi-lingual service centres process payments in 135 currencies in over 180 countries by Electronic Fund Transfer, check or wire transfer direct to members' bank accounts. We use a common claim platform for all claims that enables our customers to offer consistent benefits to all of their globally mobile employees, rather than implementing a "one size fits all" approach that can result in the administration of several different plans.

Note: Aetna does not charge a fee for wire or electronic funds transfers. Some financial institutions may charge a processing fee to receive transfers. Members should check with their financial institution to determine if any fees apply.

Designated Account Management Team and Plan Sponsor Services

Our designated Account Management team will serve as your central point of contact for all administrative and service needs. The Account Manager assigned to you will ensure a smooth implementation and ongoing account satisfaction. He or she will also work with the Account Service Representative, underwriting unit and claims team to oversee your account activity, and will meet with you on a regular basis to discuss global strategy, changing needs, financial issues, renewal activity and any other service questions that may arise. Over 91 percent of customers rate the service provided by their Account Manager as "good" or "very good"*.

Our designated Plan Sponsor Services team is structured so that all key functions are managed under one area, including implementation, enrollment, eligibility and billing. This allows for streamlined, end- to-end processing and

Superior quality control.

The Customer Implementation Management Service is closely modeled after Aetna's award-winning, U.S.-based Customer Implementation Management Service unit. Due to the complexity of many of our international implementations, we utilize a team concept to carefully coordinate all aspects of the implementation. For groups that qualify, a designated Implementation Manager will be assigned to assemble an Implementation Team and develop an Implementation Management Plan for the conversion to the new plan of benefits. This detailed plan, which is based on statistical analysis of past installations:

- Helps ensure an efficient implementation
- Identifies members of the Installation Team (including the designated Account Manager);
- Outlines the tasks to be accomplished
- Establishes target dates for the completion of each job

*2010 Account Team Satisfaction Survey conducted by DSS Research

If a change is made to the installation project, the Implementation Team makes adjustments to the timeline and alerts all impacted parties using an automatic notification process.

Awards and Accolades

Aetna is uniquely positioned in the international marketplace. Our expertise is routinely recognized by independent public, private and non-profit organizations and publications:

- "Best International Private Health Insurer for 2013"

Professional Adviser, UK (leading financial and insurance publication)

- "Health Insurer of the Year"

MENA Insurance Review (2013), Middle East and North Africa

- "International Benefits Provider of the Year"

Forum for Expatriate Management (2010, 2011)

- "Most Innovative Use of Technology in Global Mobility"

Forum for Expatriate Management (2012)

- "Most Admired Company"

Health Care, Insurance & Managed Care category
FORTUNE magazine (2008, 2009, 2010, 2011)

Aetna strives to provide our customers and their international employees with the best possible health and related benefits coverage and services. In keeping with that philosophy, we recently completed our 8th Annual Plan Sponsor Survey* to gauge our performance on current customer experiences, how we can enhance our product and service offerings and the best methods to establish better communication links with customers and their employees. As in year's past, we received positive feedback.
Here are some highlights:

- 98 percent of customers are satisfied from an overall standpoint
- 97 percent of customers are likely to recommend us to other organisations with globally mobile employees
- 97 percent of customers believe that we provide a broad range of product and service options that fully meet their needs

* Plan sponsor survey conducted by DSS Research 2010

Acknowledgement

I confirm that I have read, understood and agreed to all terms in this benefits proposal, and also the corresponding financial proposal.

Full Name of Authorised Signatory :_____

Designation of Authorised Signatory : _____

Signature : _____

Date : _____