International Healthcare Plan
Group Policy Wording
Effective date: Policies issued from 1 April 2012

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Definitions

Accident: An unexpected, unforeseen and involuntary external event resulting in injury to a member and occurring whilst this policy is in force.

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

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

Advice: Any consultation from a medical practitioner or specialist, including the issue of any prescriptions or repeat prescriptions.

Appliances: Devices and equipment when used as an integral part of a surgical procedure administered by a medical practitioner or specialist.

Area of Cover: The geographic area or specific country in which you may receive eligible treatment as stated on your benefits schedule and certificate of insurance.

Benefits: The insurance cover provided by this policy and any applicable endorsements shown in a member’s certificate of insurance.

Bodily Injury: An injury that is caused solely by an accident and results in the member’s dismemberment, disablement or other physical injury.

Certificate of Insurance: A schedule that provides members with information regarding the plan and benefit options elected by the policyholder, and lists those members, including any dependants, covered by the plan.

Chronic: A disease, illness or injury that has at least one of the following characteristics:
- It continues indefinitely and has no known cure
- It comes back or is likely to come back
- It is permanent
- Members need to be rehabilitated or specially trained to cope with it
- It needs long-term monitoring, consultations, checkups examinations or tests.

Coincidence: The percentage of the total value of incurred expenses for which the member is responsible.

Commencement Date: The date shown on the group policy, on which the policy first came into effect.

Conflict/Civil Unrest: Any war, invasion, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege or attempted overthrow of government or any act of terrorism.

Congenital Anomaly: Any genetic, physical or (bio)chemical defect, disease or malformation (except hereditary medical conditions), which is due to an influence during gestation up to birth, and which may or may not be obvious at birth.

Continuous Transfer Terms: The acceptance by us of your original date of entry as shown by your current policy will be applied to your policy with us. We will maintain your existing underwriting or special acceptance terms, as offered by your existing policy, such as any moratoria or specific exclusions and your policy with us will be governed by the terms and conditions of our policy. Any transfer will be subject to no enhanced benefits being provided. We reserve the right at all times to decline a continuous transfer terms request without giving any reason or impose/include additional exclusions.

Copay Per Visit: The amount that would normally be paid by the member to the provider when receiving treatment in the direct settlement network. Each visit shall mean for each consultation.

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

Country of Residence: The country in which members habitually reside (for a period of no less than six months per period of cover) at the time this policy is first taken out or at each subsequent renewal date.

Cover: Benefits provided to the members of a group plan.

Date of Entry: The date shown on the certificate of insurance on which a member was included under this policy.

Day Patient: A member who is admitted to a hospital bed but does not stay overnight.

Deductible: An amount that we may deduct from our reimbursement to you, equivalent to any copay or coinsurance that would normally be paid to the provider when receiving treatment in the direct settlement network.

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

Dependants: One spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with the employee, or 26 years old if in full-time education, at the date of entry or any subsequent renewal date. The term partner shall mean husband, wife or the person permanently living with the employee in a similar relationship. All dependants must be named in the certificate of insurance.

Direct Settlement: When your bill is settled directly by us, equivalent to any copay or coinsurance that would normally be paid to the provider.

Direct Settlement Network (Only available in certain countries): The medical providers where members are able to obtain treatment for valid medical conditions and where the expenses will be settled directly by us. Members are still responsible for any copay, coinsurance, excess or
**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 who is licensed by the relevant authority to practice medicine in the country where the treatment is given.

**Medically Necessary**: A medical service or treatment, which in the opinion of a qualified medical practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the member’s condition or the quality of medical care rendered.

**Member/Insured Person/You/Your**: A person who is employed by a plan sponsor, or is a covered dependant of an employee, and benefits from a group plan selected by the policyholder.

**Near Relative**: Spouse, child, brother, sister, parents, parents-in-law, sister-in-law and brother-in-law.

**New Born**: A baby who is within the first 16 weeks of its life following delivery.

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

**Outpatient**: A member who receives treatment at a recognised medical facility, but is not admitted to a hospital bed as an inpatient or day patient.

**Palliative Treatment**: Any treatment given, on advice or general advice, for the purpose of offering temporary relief of symptoms. Palliative treatment is not given to treat the underlying medical condition causing the symptoms. For the purposes of this policy, palliative treatment will include renal dialysis.

**Period of Cover**: The period of cover set out in the certificate of insurance. This will be a 12 month period starting from the date of entry or any subsequent renewal date, as applicable.

**Plan Sponsor**: A company or group that enters into an insurance arrangement with us.

**Policy**: The group health insurance policy, our contract of insurance with the policyholder providing cover as detailed in the policy documentation.

**Policy Documentation**: The set of policy documents that form a contractual agreement between us and the policyholder. These documents include any application forms, the group formation form, the certificate of insurance, the member handbook, and any other supporting documentation.

**Policyholder**: The entity that we have contracted with and to which we have issued a group policy for the provision of group insurance benefits.

**Private Room**: Single occupancy accommodation in a private hospital.

**Provider**: A provider who is legally licensed to supply treatment in the country in which it is provided.
**Provider Network:** A supplier of treatment participating in the direct settlement network.

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

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

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

**Related Condition:** Any injuries, illnesses or diseases are related conditions if we, on general advice, determine that one is a result of the other or if each is a result of the same injury, illness or disease.

**Renewal Date:** The anniversary of the commencement date of the policy.

**Semi-Private Room:** Dual occupancy accommodation in a private hospital.

**Specialist:** A registered medical practitioner who currently holds a substantive consultant appointment in that specialty, which is recognised as such by the statutory bodies of the relevant country.

**Treatment:** Surgical, medical or other procedures, the sole purpose of which is the cure or relief of a medical condition.

**Underwriters:** The carrier of risk and payer of benefits as indicated in the policy documentation and certificate of insurance.

**Ward Room:** Accommodation in a private hospital where the patient is sharing the room with more than one other patient.

**We/Our/Us:** Aetna International on behalf of underwriters as detailed in your certificate of insurance. China Life Insurance Company Limited.
1. Policy
This 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.

2. Language
This policy may only be completed in English.

3. 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.

4. 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.

5. 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.

6. 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.

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

8. Contribution
If there is any other insurance in place covering any of the same benefits, you must disclose the same to us and we shall not be liable to pay or contribute more than our proper proportion. If it is found that you were repaid for all or some of those expenses by another source, including any other insurance policy, we will have the right to a refund from you. Where necessary, we retain the right to deduct such refund from any impending or future claim settlements.

9. 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 this policy. We reserve the right to alter the policy terms or cancel cover for an insured person following a change of risk.

10. 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.

11. 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.

12. 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.

13. 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 form.
14. 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.

15. 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 the People’s Republic of China (“PRC”), and shall be subject to the non-exclusive jurisdiction of the courts of the People’s Republic of China (“PRC”).

16. 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.

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

18. 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.

19. 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.

20. 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.

21. 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 are provided for under this policy
iii) Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to our detriment
iv) Otherwise failed to observe the terms and conditions of this policy or failed to act with good faith.

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

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

24. 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.
25. 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 this 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 ongoing cover and member safety.
Appendix: benefits schedule detail

Your policy may include some of the following benefits. To confirm the benefits included in your policy, please refer to your benefits schedule.

All benefits are subject to the maximum annual aggregate limit and the sums insured indicated in your benefits schedule, the applicable medical underwriting, the member’s certificate of insurance and our general conditions and exclusions.

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.

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.

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 inside the USA 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 in the USA and where the medical condition did not exist prior to travel and the member was treatment-, symptom- and advice-free. For outpatient treatment, a benefit excess applies.

In the event of accident and emergency treatment being required inside the USA, the member should contact us either before or as soon as possible after admission to the accident and emergency unit of the hospital.

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

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.

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.

Hospital Cash: 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.

For this benefit, the policy excess does not apply.

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.

DISEASE AND CHRONIC CONDITION MANAGEMENT

Oncology: Covers 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.

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.

For this benefit, the policy excess does not apply.

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. This benefit excludes any hereditary medical conditions.

Durable Medical Equipment, Prosthetic and Orthotic 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 calipers, 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.

Hospice Care: Treatment provided by a hospice for the care of a member upon diagnosis of a terminal illness. Such treatment will cover:

i) Palliative treatment and other acute and chronic symptom management.

ii) Medical social services under the direction of a medical practitioner or specialist.

iii) Physiological and dietary counselling.

iv) Consultation or case management services by a medical practitioner or specialist.

v) Part-time or intermittent qualified nurse services for up to eight hours in any one day for outpatient care.

Hormone Replacement Therapy: Medical practitioner or specialist consultations and the cost of prescribed tablets, implants or patches when treatment is for the female menopause, which has been induced artificially and/or through early onset (by early onset we mean prior to age 40).

OUTPATIENT AND ALTERNATIVE TREATMENTS

Outpatient Care: 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.

Outpatient Psychiatric Treatment: For outpatient psychiatric treatment, including specialist consultations, all treatment must be pre-authorised by us and must at all times be administered under the direct 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 a medical practitioner (not a psychiatric specialist), which results in a psychiatric referral, is covered without the requirement for pre-authorisation.

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.

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 benefit is pre-authorised by us.

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 & Additional Travel Expense: Evacuation of a member in the event of an emergency, where treatment is not readily available at the place of the incident, 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. 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.

**Compassionate Emergency Travel:** Reasonable travel and accommodation expenses in respect of one member, together with any minors (under the age of 16) necessarily having to travel to and the return journey from the normal country of nationality or country of residence of a near relative who has unexpectedly been placed on the critical list following an accident.

**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.

**MOTHER AND CHILD BENEFITS**

**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 infertility treatment (assisted conception) 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.

**New Born Care:** Inpatient treatment of an acute medical condition being suffered by a new born baby that manifests itself 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 manifests itself 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).

**New Born Accommodation:** 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.

**ADDITIONAL OPTIONS TO UPGRADE COVER**

**Alternative Treatment – Without medical referral:** Treatment administered by registered chiropractors, osteopaths, homeopaths, podiatrists and acupuncturists.

**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.

The policy excess does not apply.

**Compassionate Emergency Travel:** Reasonable travel and accommodation expenses in respect of one member, together with any minors (under the age of 16) necessarily having to travel to and the return journey from the normal country of nationality or country of residence of a near relative who has unexpectedly been placed on the critical list following an accident.

**Congenital Anomalies – Including Pre existing Congenital Anomalies:** Treatment of congenital anomalies. This benefit excludes any hereditary medical conditions.

**Complications of Pregnancy – No Wait Period:** 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

**ADDITIONAL OPTIONS TO REDUCE COSTS**

**Outpatient Consultation Copay per Visit:** This benefit is available where nil excess has been selected. Outpatient consultations taking place in the network are subject to a copay per visit. Where consultations take place out of network, or a claim is submitted by the member for reimbursement, a deductible is payable for each visit.

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) Hormone replacement therapy (HRT)

v) Oncology

vi) Outpatient care

vii) Outpatient psychiatric treatment

viii) Outpatient surgery

**Inpatient Bed Limit:** Inpatient bed costs are restricted to the selected inpatient limit, unless in respect of HDU and ITU admissions, which remain fully covered.

**Hong Kong Semi-Private Room Restriction:** This benefit is available to residents of Hong Kong only. This benefit fully refunds the cost of a semi-private room or corresponding rates when receiving treatment as an inpatient or day patient.

**China Private Room Restriction:** This benefit is available to residents of mainland China only. Benefit is restricted to semi-private room and corresponding rates when receiving treatment as an inpatient or day patient outside mainland China.
result of assisted conception including (but not limited to) premature or multiple births are excluded from this benefit.

Dental 1 – 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. For this benefit, the policy excess does not apply.

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 2 – Major Restorative Dental Treatment: This benefit 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
• 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, routine treatment and dental implants.

For this benefit, your policy excess does not apply.

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 3 – Orthodontic Dental Treatment: This benefit must be purchased in conjunction with Routine Dental or Major Restorative Dental treatment. It covers the fees and associated costs of a dental practitioner carrying out orthodontic treatment in a dental surgery. This benefit is limited to any member up to and including 18 years of age.

For this benefit, your policy excess does not apply.

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 4 – Dental Implants: The treatment and cost of dental implants.

For this benefit, policy excess does not apply.

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 5 – Combined Routine & 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.

For this benefit, your policy excess does not apply.

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 6 – Combined Routine & Restorative Dental with Orthodontics: 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)
Orthodontic treatment covers the fees and associated costs of a dental practitioner carrying out orthodontic treatment in a dental surgery to any member up to and including 18 years of age.

This benefit excludes dental implants.

For this benefit, your policy excess does not apply.

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 7 – Combined Routine & Restorative Dental with Orthodontics and Dental Implants: 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
- 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)

Orthodontic treatment covers the fees and associated costs of a dental practitioner carrying out orthodontic treatment in a dental surgery to any member up to and including 18 years of age.

Dental implants covers the treatment and cost of dental implants.

For this benefit, your policy excess does not apply.

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

Outpatient Direct Settlement Network - nil excess:
Outpatient consultations are available on a Nil excess basis where treatment is received in network. The policy excess applies where consultations take place out of network.

Outpatient consultations for the following benefits are covered subject to their inclusion in your plan, and up to the value of cover selected in your plan:

i) Complications of pregnancy
ii) Congenital anomalies
iii) CT and MRI scans
iv) Hormone replacement therapy (HRT)
v) Oncology
vi) Outpatient care
vii) Outpatient psychiatric treatment
viii) Outpatient surgery

Extended Evacuation: This benefit covers the evacuation costs of a member in the event emergency treatment is not readily available at the place of incident, to the nearest appropriate medical facility, country of residence, country of nationality or country of the member’s choice for the purpose of admission to hospital as an inpatient or day patient, including the cost of one other person to travel with the member as an escort if medically necessary.

Evacuation 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 in the place of incident. The member’s country of choice is limited to appropriate medical facilities being in place and where it is medically suitable at our discretion. This option is not operative where travel is undertaken against the advice of our medical advisors or where the nominated country does not have the appropriate facility to treat the medical condition. Our medical advisors will decide the most appropriate method of transportation for the evacuation.

This benefit excludes any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts, all maternity and childbirth costs except where these are covered under the benefit for Complications of Pregnancy, and elective treatment in the USA unless this benefit has been purchased and appears on the member’s benefits schedule.

Out of Country Transportation: 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.

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.

Hearing Benefit: The cost of one annual hearing test and hearing aids.

For this benefit, your policy excess does not apply.

Infertility Treatment (minimum of 10 employees required):

Ovulation induction induced via certain oral or injectable infertility medication, Artificial Insemination, and Advanced Reproductive Technology (ART) procedures and In vitro fertilisation (IVF) with embryo transfer.

This benefit requires preauthorisation prior to any treatment taking place and approval of medication and procedures to be undertaken.

The following exclusions apply:
- Couples in which one of the partners has undergone a sterilisation procedure with or without a surgical reversal.
- Females with FSH levels 19 mIU/ml or greater on day 3 of their menstrual cycle, or who manifest a positive Clomid challenge.
- Charges for: the purchase and storage of donor sperm, the care of the donor required for donor egg retrievals or transfers, Cryopreservation or storage of cryo-preserved embryos.
• ART for women without male partners who have not had at least 12 cycles of donor insemination prior to enrolling in the Infertility Programme for ART (6 cycles if the member is age 35 or older).

• Charges associated with a gestational carrier programme (surrogate parenting) for either the member or the gestational carrier.

**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 previous non-emergency caesarean sections undertaken. This benefit covers the cost of pre- and post-natal checkups for up to six weeks, prescribed pre natal vitamins, and delivery costs, including qualified Midwives. 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 neo-natal, new born packages (including elective circumcision) and costs incurred for the care of the baby or babies for the first 24 hours following birth when the baby is accompanying its mother (being a member) whilst she is receiving treatment as an inpatient in a hospital.

For this benefit, your policy excess does not apply.

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

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

For this benefit, your policy excess does not apply.

**USA Elective Treatment:**

i) Inpatient or day patient treatment received in-network

ii) Inpatient or day patient treatment received out-of-network (subject to 50% coinsurance)

iii) Outpatient treatment

All planned inpatient and day patient treatment must be notified to us prior to commencement of treatment.

The International Healthcare Plan (IHP) does not comply with the Patient Protection and Affordable Care Act (U.S. healthcare reform), and cannot be used to satisfy any requirements for health insurance cover mandated therein.

**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.

For this benefit, your policy excess does not apply.

**Wellness Option 1:** This benefit covers the cost of:

i) Routine medical checkups and associated tests. Such routine checkups/tests include: 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.

ii) Well-baby checks following the first 24 hours including 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; all as recommended by a medical practitioner or specialist.

For this benefit, your policy excess does not apply.

**Wellness Option 2:** This benefit covers the cost of:

i) Bilateral mammogram/breast examination and routine gynaecological tests including PAP tests.

ii) Testicular/prostate examination/PSA/DRE tests.

iii) Routine medical checkups and associated tests. Such routine checkups/tests include: 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.

iv) Well-baby checks following the first 24 hours after birth, including 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; all as recommended by a medical practitioner or specialist.

For this benefit, your policy excess does not apply.

**Wellness Option 3 Preventive Screening:** Preventive screening for members who are deemed at high risk of cancer because of family history of familial adenomatous polyposis or hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease, family history of breast, ovarian, endometrial, colon cancer or polyps, or a background, ethnic or lifestyle, such that the health care provider treating the member believes he or she is at elevated risk, shall include a screening by colonoscopy, barium enema or any combination of the most reliable, medically recognized screening tests available.

For this benefit, your policy excess does not apply.
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) 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).

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. Hereditary medical condition(s).

5. 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. This exclusion is removed if the benefit for congenital anomalies including pre-existing conditions has been purchased.

6. 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.

7. 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.

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

9. Treatment received in health hydro, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments, or a hospital where the hospital has effectively become the member’s home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

10. Cosmetic treatment, and any consequence thereof.

11. Treatment for weight loss or weight problems whether or not preceding or as a consequence of a psychiatric condition and any associated treatment costs consequent of cosmetic surgery or arising as a result of an eating disorder or weight problem, including any required psychiatric treatment where the psychiatric condition is a related condition to the eating disorder.

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

13. 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.

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

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

16. 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.

17. Treatment directly or indirectly arising from (or required in connection with) male and female birth control, sterilisation (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.

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

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

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

21. 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.

22. 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).

23. 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.

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

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

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

27. 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).

28. 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.

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

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

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

32. 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 a Medical History Disregard Basis or the benefit for Complications of Pregnancy with no wait period has been purchased.

33. 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.

34. Hazardous activities, including 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.

35. All benefits are excluded unless they appear on your benefits schedule.
Your guide to making a claim

In order to ensure that members receive the best possible claims service, the procedures noted below should be followed in the event of treatment being required.

Please ensure your claim form is completed in full and returned within 180 days of the treatment date.

CLAIM SUBMISSION

We reserve the right to deny any claim that is not submitted within 180 days of the treatment date. Claims may only be made for treatment given during a period of cover. The benefit will only be payable for expenditure incurred prior to expiry or termination.

All required supporting claims documents and materials (including, but not limited to, original accounts, certificates and x-rays) shall be provided without expense to us. This includes medical reports from your medical practitioner or specialist and details of your medical history, if requested by us.

Charges from an attending medical practitioner or specialist for completing claim forms are not eligible for reimbursement under the terms and conditions of this plan. Members will be responsible for these costs.

We will require a medical practitioner’s or specialist’s referral to be included whenever filing a claim for the following treatments:

i) Chiropractic treatment
ii) Acupuncture treatment
iii) Osteopathic treatment
iv) Homeopathic treatment
v) Podiatric treatment
vi) Physiotherapy (additional referral by a specialist required after 10 sessions)

We accept copies of original receipts to initiate the claim process and to facilitate the assessment of your claim (i.e., if you submit claims via fax or e-mail); however, we require that you send the originals before any claims payment is made by us.

CLAIM NOTIFICATION

The policyholder, or the insured person, shall inform us promptly upon becoming aware of the insured incident. When the policyholder, or the insured person intentionally or due to material default fail to inform us in a timely way and this causes difficulty in identification of the nature, cause, degree of loss, etc., then we shall not be liable for payment of insurance compensation for the portion that cannot be identified, with the exception that we ought to have know such incidents through other channels.

PRE-AUTHORISATION

We require members to obtain prior approval (pre-authorisation) from us before commencing the following treatments:

i) Planned inpatient or day patient treatment (hospitalisation)
ii) Any pregnancy or childbirth treatment
iii) Planned surgery
iv) Home nursing charges
v) Planned MRI, PET and CT scans
vi) Infertility treatment (if purchased)
vii) Outpatient psychiatric
viii) Planned MRI, PET and CT scans
ix) Infertility treatment (if purchased)

We also require pre-authorisation when seeking emergency evacuation.

EMERGENCY/EVACUATION

In the event of a true medical emergency or evacuation, members may contact us at the appropriate number found on your Aetna International membership ID card.

INPATIENT AND DAY PATIENT TREATMENT

Our prior approval (pre-authorisation) must be obtained for all planned day patient and inpatient treatment.

Inpatient and Day Patient Treatment outside the U.S.

When we have been notified of an eligible day patient/inpatient stay, we will attempt to arrange direct settlement with the hospital and the medical practitioners or specialists concerned. We will send the hospital a guarantee of payment for the estimated cost of the treatment, as indicated by the relevant facility/provider, which will confirm to them that the treatment is covered under your plan.

• Release of Medical Information Form
  You will be required to complete a release of medical information form, which you should forward to us as soon as possible. Delays in completing this may result in delays in receiving treatment.

• Pre-certification Medical Form
  The hospital is required to complete a pre-certification medical form outlining details of the medical condition and treatment to be undertaken. We cannot place a guarantee of payment without these two documents, so please ensure that the hospital confirms with you that this has been sent to us. We will verbally confirm that your treatment is covered under the terms of the group plan. However, completion of pre-authorisation is conditional on the submission of our guarantee of payment. We will notify you as soon as possible if the condition or treatment required is not covered.

It is important to contact us as soon as possible prior to treatment to ensure we are able to place a guarantee of payment in time. We recommend that you do not delay treatment if a guarantee is not in place at the time treatment is due.

Day Patient and Inpatient Treatment in the U.S.

For those members who benefit from U.S. elective treatment or those eligible to claim accident and emergency treatment outside the area of cover as a direct result of treatment being undertaken in the accident and emergency ward of a hospital whilst temporarily travelling in the U.S. and where the medical condition did not exist prior to travel.

Please check your certificate of insurance to ensure that you have the appropriate cover before travelling to or undertaking any treatment in the USA.
For emergency admissions, the member, the hospital or a family member should contact us to obtain authorisation prior to your leaving the hospital. Failure to notify us of inpatient or day patient treatment will mean that you may only be eligible for reimbursement of a proportion of the costs incurred.

- **Inpatient or Day Patient Treatment in the U.S. Provider Network**
  
  We have made arrangements with many provider networks in the USA, which mean that costs for treatment at these facilities can be settled directly by us.

  Treatment received within the provider network will be billed to us directly. Our claims department will determine what portion of the invoice is applied to your excess and which portion is payable by us. We will send you and the provider copies of the explanation of benefits (EOB) detailing how the bill was settled and what amount you are responsible for.

  We will notify you as soon as possible if the medical condition or treatment required is not covered by your plan.

- **Inpatient or Day Patient Treatment in the U.S. received outside the Direct Settlement Network**

  Treatment received outside the U.S. provider network is subject to limitation and a 50% coinsurance.

**OUTPATIENT TREATMENT**

To ensure prompt settlement of claims, please take your claim form with you in order for it to be completed by the treating practitioner or specialist.

**Outpatient Treatment inside the Direct Settlement Network (outside the U.S.)**

For those in the relevant participating countries, we have arranged a direct settlement network enabling members to obtain outpatient treatment (as defined in the certificate of insurance) at a number of selected medical centres where all eligible treatment charges will be paid directly by us.

When seeking eligible outpatient treatment at any of the participating centres, it is important that you present your personal Aetna International membership card to the medical centre/service provider before treatment begins in order to ensure that you are not asked to settle any treatment costs. You may be responsible for paying a per visit copayment to the provider but this will be clearly shown on your membership card.

  - Present your Aetna International membership card to the medical centre/provider on arrival.
  - Have a second form of identification available should it be required by the reception staff.
  - Check the claim form that the medical centre will provide after your treatment and sign it to confirm that you have received the treatment stated.
  - Settle any charges made by the medical centre, which relate to either items not covered or ineligible treatment that you may have received.

**IMPORTANT:** Please remember that your Aetna International membership card should not be used to obtain treatment that is excluded from cover.

**Outpatient Treatment outside the Direct Settlement Network (outside the U.S.)**

After paying for treatment, you must submit a claim form to us for reimbursement.

If we require medical information when considering a particular claim, but it is not made available to us, it is your responsibility to obtain this information from your current or previous medical practitioner or specialist, as appropriate.

It may not always be possible to have your claim form completed by your medical practitioner, specialist or dental practitioner. In such circumstances, we will settle the claim, provided that the submitted invoice(s)/receipt(s) for treatment are included and contain all of the following:

- The date of service
- The diagnosis or medical condition being treated
- The treatment provided during the visit
- The charged amount
- The stamp of the facility/provider concerned

If physiotherapy, acupuncture, chiropractic, osteopathic, podiatric or homeopathic treatment is required, please ensure that you include a referral letter from your medical practitioner or specialist with your claim.

Settlement of claims may be delayed if you fail to complete your claim form(s) properly. To ensure prompt settlement of any eligible claims, please ensure that you submit all necessary documents at the time of the claim.

**One Time Direct Settlement**

Exceptions may be made for high cost procedures. In this case, members are required to contact us prior to receiving treatment, in order for us to attempt to arrange direct payment with the medical facility concerned. Please note that not all medical facilities will accept direct payment from us. In these instances, you will be required to settle the bill and submit a claim to us for reimbursement.

**Outpatient Treatment in the U.S.**

For those who have purchased the U.S. elective treatment benefit or those temporarily travelling in the U.S. and claiming accident and emergency treatment outside area cover benefits for outpatient treatment connected with treatment received in the accident and emergency ward of a hospital for a medical condition that did not exist prior to travel.

Please check your certificate of insurance to ensure that you have the appropriate cover before undertaking any treatment in the USA.

Where your policy allows, outpatient services and treatment received within our provider network can be billed to us directly. Prior to seeking treatment, we recommend that you contact our Member Services team who can check the location of your nearest participating provider.

Members are required to show their membership card to the provider who will contact us to confirm direct billing. This may not happen immediately and, should you be asked to pay for the treatment, please ensure you state clearly to the facility that you wish to have your bill settled directly by us, and for them to contact the number on your Aetna International membership card.

Our claims department will process the claim according to the applicable portion payable by us, taking into account your excess and any coinsurance applicable. Once our portion is paid, we will send both you and the provider an explanation of benefits (EOB) with details of settlement and a statement of what you are responsible for.
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Summary of our complaints handling procedures

Complaints will:

• Be acknowledged promptly, confirming who will be responsible for investigating the complaint.
• Be investigated competently, efficiently and impartially, ensuring that we provide updates on progress.
• Be assessed fairly, consistently and promptly.

Where a complaint relates to the services provided by another firm we shall advise the complainant of this and forward the complaint to the other firm for resolution. Where we and another firm are jointly responsible for the complaint, we shall ensure that the complainant is informed of this and each company will contact them directly in relation to the complaint for which it is responsible.