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华泰保险
Huatai Insurance Group

华泰全球至尊健康 团体医疗保险计划

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www.aetnainternational.com



欢迎来到 Aetna 安泰国际， 非常荣幸有您的加入。

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现在，您已经成为 Aetna 安泰国际的会员， 本手册可以帮助您轻松地了解保险计划及服务内容。

安泰国际会员健康门户

www.aetnachina.com.cn/CHNHH/index.do

现在您该做什么？

最重要的第一步是登录并注册安泰健康门户的会员，该门户帮助您更好的使用保险计划所需的工具。注册步骤简单、快捷：访问 www.aetnachina.com.cn/CHNHH/index.do，输入您的会员卡号、您的姓名及出生日期。

您可通过该健康门户：

- 更新您的会员信息，例如地址及其他重要信息；
- 查阅您的保险凭证及保障内容；
- 申请预授权；
- 提交及追踪您的理赔申请；
- 查询历史理赔件信息；
- 查询周边的网络医院；
- 阅读您的健康风险评估报告；
- 了解安泰原创健康管理系列话题；

您的 Aetna 安泰会员卡

Aetna 安泰会员卡是您享受优质医疗服务的钥匙，请妥善保管。在网络医院就诊时，请出示您的 Aetna 安泰会员卡。注册会员健康门户或致电会员服务中心时，也请将它放在手边以方便随时查看。

联络我们

您可以通过拨打安泰会员卡背面的热线电话联系我们，亦可以通过以下方式：

地址：上海市黄浦区蒙自路 757 号，歌斐中心 702 室

邮编：200023

电话：+86 400 881 1291

传真：+86 21 6326 8525

邮箱：HTChinaServices@aetna.com

关于您的保险计划

花些时间了解您保险计划的保障内容，这非常重要。

您可以登录安泰会员健康门户网站，阅读您保险合同的相关重要文件。登录后请点击“我的帐户，我的保单”，然后再点击“保单文件”，该文件将概述您的保障内容。您还可参考本手册第七页查阅关于本保险计划的其他重要信息。

使用直接结算网络

您可以使用我们的直接结算网络快速办理住院，轻松支付。该网络内的顶尖医院和诊所遍及全国各地。我们将直接与网络内的医疗供应商直接结算您全部或部分的医疗费用，从而降低您在医疗机构实际需要支付的费用。

直接结算对您意味着：

- 更便捷的提交理赔申请；
- 额外的理赔款申请及预付费选项；
- 降低在医疗机构的实付费用；
- 保障理赔确认信直接寄送至医疗机构。

您可登录安泰会员健康门户在线搜索直接结算网络的供应商名单。当然，您还可以拨打安泰会员卡背面所列电话号码，致电我们会员服务中心以获得帮助。

若您倾向于访问某个直接结算网络外的医疗提供商，您可申请进行一次性直接结算，我们将尽量为您安排。请注意，并非所有医疗机构均接受我们的直接结算。在我们无法进行直接结算的非网络医院，您需要先自行结算账单，支付医疗费用，然后再向我们提出理赔申请，获得理赔款。

如何就诊

1. 登录安泰会员健康门户，点击“直接直付网络”查找附近的直接结算网络的医疗机构。您也可以致电我们寻求帮助；
2. 安排预约，请确认您本人或您的家庭成员是 Aetna 安泰的会员。
3. 就诊时请出示您的安泰会员卡。

关于预授权

您可能需要获得提前批准（预授权）方可进行特定类型的医疗程序。这种情况下，尽早开始申请流程很重要，以免您的理赔申请被推迟或被拒。

最佳做法，先与您选定的医疗供应商确认预授权申请的流程。某些情况下，他们可能为您直接处理此事。若医疗供应商通知您自行获得预授权，您可以登录安泰会员健康门户进行申请，或拨打安泰会员卡背面的热线电话寻求帮助。

要求申请预授权的医疗程序：

- 计划住院或日间留院治疗；
- 妊娠或分娩治疗（常规产前检查除外）；
- 计划手术；
- 家庭护理费；
- 计划磁共振成像（MRI）、正电子发射型计算机断层显像（PET）及计算机断层扫描（CT）；
- 不孕症治疗（若已购买）；
- 门诊精神病治疗；
- 紧急护送转院

若您需要急诊，请勿延误治疗。

若您需要住院治疗

若您知悉您需要住院治疗，应尽早与我们及您的医疗供应商联系，以确保您了解您的保险计划的保障范围。这还将有助于避免之后的理赔延迟。

在住院前，您可拨打安泰会员卡背面的电话号码联系我们，提供治疗详情。如果您的住院治疗属于计划外的急诊，请在合理情况下尽快联系我们，以便我们在您的保障计划范围内进行预授权。

医疗护送转院

若您需要到其它地区接受必需的医疗服务，您将在途中每一站得到您需要的支持。我们团队会帮助协调您的交通及护理的相关事宜。

我们拥有全球最值得信赖的医疗护送转院合作伙伴，航空救护提供商，紧急途中援助和安全服务。这些服务要求预先核准，因此请提前联系我们申请相关预授权，以确保您在保险计划保障范围内获得预先批准。

为您的健康需求提供帮助

医疗管理团队

若您有医疗方面的问题，您可致电医疗管理团队获得帮助。该临床医生团队每天 24 小时、每周 7 天、每年 365 天在线服务，可在您旅行前、旅行中及旅行后的任何时间向您提供解答和帮助。

您可得到以下方面的帮助：

- 出行前计划；
- 协调在全球范围内常规和紧急医疗服务；
- 帮助寻找医疗服务供应商或专家；
- 协助获取医疗设备或处方药；
- 协助获取处方药和医疗器材；
- 协调取得疑难杂症的第二诊疗意见；
- 协调完成治疗后返回国籍国的护理；
- 出院规划；
- 产科管理。

若您或您的家人遇到某种慢性健康问题或已怀孕，应尽早的向安泰医疗管理团队咨询，我们能为您和您的家人提供专业的医疗、医护及医药建议和服务。您可通过安泰会员卡背面的号码与我们联系，或登录安泰会员健康门户，点击“联系 CARE 团队”。

拥有健康、保持健康

您可参与健康风险评估，以帮助您获得健康，并保持健康。该项保密的调查通过提供正确的问题、推荐及服务帮助您对自身健康作出积极调整。

您可登录安泰会员健康门户，点击“开始健康评估”参与评估。

如何提交理赔申请

下面是提交理赔申请时应牢记的一些重要事项：

请完整填写理赔申请表并签名。每一名家庭成员需要单独一份理赔申请表，表中须列明所有就诊疾病。

除了完整填写的理赔申请表，您还需提供以下材料：

- 医疗原始发票及费用清单（药费、检查费、治疗费和其他费用）
- 完整的病历资料，包括但不限于门急诊病历、药品处方及医学检查报告。住院提供出院小结复印件
- 若索赔金额高于 1 万元人民币或外币等值 1 千美元，需提供收款人的护照/有效身份证正反面复印件。

如何提交理赔

我们为您提供了灵活的理赔递交方式。

如果您的理赔符合以下条件，您可以通过邮件或者安泰会员健康门户在线递交您的索赔申请：

- 在中国大陆境外发生的治疗；或
- 在中国大陆境内发生的门诊治疗：
 - i. 同一天内在门诊同一科室就诊的所有发票面值总和不高于（含）人民币 3,000 元；并且
 - ii. 同批次递交的所有发票面值总和不高于（含）人民币 3,000 元。

进入 www.aetnachina.com.cn/CHNHH/index.do，登录您的安泰会员健康门户。

- 点击“我的理赔”→“提交理赔”
- 根据网站提示步骤填写并上传完整理赔信息及材料
- 提交您的理赔申请。

同时，请保管好发票原件，因我们保留向您索取发票原件的权利。

对于其他不符合上述条件的理赔，您可通过普通信件或快递等方式提交理赔申请。请将完整填写的理赔申请表和其他必需的理赔材料邮寄至：

安态（上海）企业服务有限公司理赔部，上海市黄浦区蒙自路 757 号歌斐中心 702 室，邮编 200023。

一般条款

1. 保险单

本保险合同包括保险单（团体保单）、团体投保申请书或其他申请表、与投保人约定的当前保险费率以及保单文件，包括保险凭证、保障一览表和会员手册。投保人、任何受保员工或受益人的权利将受到上述条款而非其他任何条款的影响。

2. 语言

本保险单可使用中文或英语书写。

3. 投保资格

新申请人投保资格为 65 岁以下者。任何在 30 天的投保资格期内未进行登记的员工或家属须接受个人核保。

新生儿的投保自其出生之后受理（受新生儿保障限制）。出生后 30 天内接到书面通知，且接到通知后 30 天内收到全额保险金的，可办理新生儿投保。

在合同生效日或续保之日，不满 18 周岁且与员工一起居住，或正在接受全日制教育的不满 26 周岁的子女，可在合同生效日或此后任一续保日作为被保险人的家属进行投保。子女必须随父母或合法监护人一起参保，且参保各方享有同等的保障。

人工受孕出生的连带被保险人需提交一份健康声明。我们保留不予任何解释驳回申请之权力。

4. 保险终止出现下列情况，保险将可能终止

- i. 您的雇主撤销或终止团体保险计划。
- ii. 您自愿停止团体保险计划所涉及的保险。
- iii. 您不再符合受保条件（例如：您的雇佣关系解除）。
- iv. 您已用尽团体保险规定的年最大保险赔偿总额。
- v. 如果我们通知您，我们已支付治疗或疾病费用，但该费用不在团体计划条款规定范围内，在接到通知后 14 天内，您未能向我们偿还该费用。

5. 理赔范围

保险人将依照下列约定给付保险金（各项保障金额将不会超过各项保障相应支付限额，所有保障的总金额不得超过双方同意的保险单最高保障金额）；所有费用必须是医疗必需的合理且惯常的费用。

本保险合同承保针对会员在当前保险期间内发生的疾病治疗费用。

6. 保险期

保险期间在保险单（团体保险单）中载明，以在保险单（团体保险单）和保险凭证中载明的开始和终止日期为准。会员的计划从保险凭证所注明的保险期间开始生效。其后，保险期间将每年进行续期。

7. 保险单文件

保险人将在保险合同订立后，及时向投保人签发保险单。保险人将为此保险单中的每一位会员以及所有符合条件的连带会员提供保险凭证。

8. 共同分摊

如已投保任何其它可获得相同保障内容的保险，您须将此相同内容告知我们，对于超出我们适当份额的部分，我们将不予赔付。

9. 风险变更

在合同有效期内，保险标的的危险程度显著增加的，会员应当按照合同约定及时通知保险人，保险人可以按照合同约定增加保险费或者解除保险合同。

10. 重要事实说明

所有会影响我们对申请的评估的重要事项（比如，先前的健康状况或危险活动的参与）均需事先声明。如果您未作此声明，您的团体保险计划可能会因此而无效。如果您不能确定此事项是否重要，敬请告知。

11. 违约

无论因任何原因，会员的保险期间出现中断，保险人保留对会员的既有伤病使用免责条款第 1 条的权利。

12. 索赔通知

请务必完整填写理赔申请表，并在治疗结束后 180 天内递交给我们。关于更多详细介绍，请见第 14 页的理赔章节。

13. 理赔

如果我们发现所递交的索赔申请和相关资料不充分，将立刻通知您补交相关材料。

如果您已提交所有索赔相关材料，我们将按照您理赔申请表中规定的付款方式为您进行赔偿。

14. 欺诈/无理由索赔

涉嫌欺诈或无理由索赔的，与该次索赔相关的所有已赔付和/或应赔付保障将被没收且可以撤回（如适用）。此外，自投保日起，与该会员相关的所有保险保障将予以撤销作废。

15. 适用法律

本保险单的适用法律会在保险凭证中予以规定。如果未载明法律规定，则保险单将按照中华人民共和国（“中国”）法律予以解释，且应接受中华人民共和国（“中国”）法院的非专属司法管辖。

16. 代位求偿权

发生保险责任范围内的损失，应由有关责任方负责赔偿的，保险人自向会员赔偿保险金之日起，在赔偿金额范围内代位行使会员对有关责任方请求赔偿的权力，会员应向保险人提供必要的文件和所知道的有关情况。

会员已经从有关责任方取得赔偿的，保险人赔偿保险金是可以相应扣减会员已从有关责任方取得的赔偿金额。

被保险人必须全力配合我们收回已付款项，包括我们将进行的以及我们自行决定代表被保险人进行的法律诉讼。在任何一方（包括保险公司或代理人）接到通知按照您的意愿提出索赔要求或调查索赔事件，因被保险人所承受的伤害、病症或疾病追讨损失或获取赔偿的 30 天内，被保险人必须向我们告知相关事宜。未经我们书面同意，被保险人无权就任何可能的事件承担责任或就任何对其有约束力的保证进行许诺。如果因代位求偿权或合约中的任何部分引起索赔或纠纷，包括但不限于模棱两可的追偿权条款或关于其条款意义或意图的问题，为避免疑义，对因本条款解释而引起的纠纷，我们将全权负责。

17. 家庭/家属受保

员工及其家属应投保在同一团体保险计划接受相同保障。

18. 投保资格

保险人有权无条件拒绝接受任何人的申请。保险人有权要求投保人在申请中提供年龄证明和/或健康申明。保险人有权使用附加选项、责任免除、或增加保险费来应对投保人或会员在其申请表中表明的情况，或作为重要因素向保险人申报的情况。

19. 医疗鉴定

当我们认为索赔条件可能直接或间接地涉及到责任免除条款时，我们保留要求进一步检验和/或鉴定的权力。

20. 豁免

在任何情况下，保险人对于本保险单任何条款的弃权均不会影响将来其它情况下对该条款的使用。这包括，但不限于，保险费或保险赔偿的支出。

21. 我们撤销保单的权利

如果投保人未能支付任何保险费，我们有权撤销保险单和任何相关保险/计划。我们可决定在后续保费补交后恢复保险，但保险利益可能会有所变更。

如果会员或者投保人出现以下行为，我们可以随时终止其保险：

- i. 用不实言论误导我们。
- ii. 出于非本保险单规定原因的其他目的，故意套取保险赔偿。
- iii. 同意第三方尝试获取不正当金钱利益，从而对我们的利益造成损害。
- iv. 未能遵守本保险单条款或未能真诚履行责任。

22. 责任

任何原因造成保险单终止的，我们的责任即刻终止。此原因包括但不限于，不续约和未支付保险费。

23. 合同当事方

本合同的当事方只有投保人和保险人。

24. 货币

本保险单的货币限定为与保险费相同的货币。使用当地货币支付的理赔案件将根据被保险人接受治疗之日在 www.oanda.com 网站上登载的汇率进行兑换后赔付。

25. 冲突或内乱、化学或放射性污染

由冲突或国内动乱、化学及核材料或核燃料燃烧或任何其它相关情况引起的化学或放射性污染直接或间接产生的医疗费用及支出均属于本保险单的理赔范围，前提是会员：

- i. 不是冲突或内乱的积极参与者
- ii. 未参与直接或间接导致伤害或病患的非法行为
- iii. 在不知情的情况下进入发生冲突、国内动乱、自然灾害、化学、核或放射性污染的国家、地区或地点或在这些地方逗留
- iv. 无意中身处由冲突、国内动乱、自然灾害、化学、核或放射性污染导致的病患或伤害风险之中
- v. 并非任何武装力量、安保部门成员，包括保镖以及任何类型的化学、核或放射性污染清扫人员（包括政府或私人工作者）。

基于在保险生效日或续保日所提供的信息，Aetna 会评估会员在高风险地区当前、未来或发展中的风险暴露程度，同时会将维持保险和会员安全所需的任何行为、限制、免责条款或附加保险费通知投保人。

免责条款

1. 会员就任何疾病或相关疾病接受过治疗，且在合同生效日之前症状已存在并为会员所知，或者会员就此寻求过诊断意见（既往疾病），除非会员已向我们声明上述疾病并获得书面认可。在经过连续参保满两年后，如果未出现以下情况，会员的既往疾病（或相关疾病）将被认可（就该症状而言），视为会员具备获取保障内容的资格，但不包括先天性疾病或畸形：
 - i. 向任何医生或专科医生寻求过治疗或诊断意见（包括体检）。
 - ii. 出现过进一步的症状。
 - iii. 服用药物（包括药品、特殊饮食或注射）。
2. 肾衰竭的支持性治疗，包括透析（除非您的保障计划已包括慢性病保障）。

然而，我们仍将赔付下列情况中的肾透析费用：

 - i. 手术前后短时间内。
 - ii. 发生在急性继发性肾衰竭监护期间。
3. 我们根据一般意见认定为实验性质或疗效未经证实的治疗。
4. 在投保日之前已存在或寻求过诊断意见的先天异常，但年龄小于 12 个月的婴儿除外。若已购买涵盖投保前疾病的先天异常保障，则此免责条款取消。
5. 医生开具的预防性药物和进行的常规检查和体检，包括妇科检查（已购买体检保障的除外）。常规的听力测试（已购买听力保障或健康听力和视觉保障的除外）。
6. 非病理性/自然性的视力退化，包括但不限于近视、远视、散光以及任何针对非病理性/自然性视力退化的矫正性手术。此项免责条款包括常规视力检查，除非已购买并在保险凭证上载明视力检查保障。
7. 康复治疗，但不包括康复保障中列明的内容。
8. 在健康水疗院、自然疗法诊所、美容院或附属于此类机构接受的治疗；任何非正规医疗治疗手段或服务，如按摩，水疗，气功等或者在已成为会员住所或长期住处的医院，或者全部/部分因为家庭原因而入院所接受的治疗。
9. 整容治疗及其导致的任何结果。

10. 任何为减轻体重或与体重相关问题而接受的治疗，包括但不限于肥胖疗程，减肥药品或补充剂，健康会所会员资格，节食疗程以及在疗养机构进行的针对饮食异常的治疗。任何因减轻体重或其它除外的项目引起的并发症。
11. 替代疗法，包括但不限于催眠疗法和哺乳检查及治疗。
12. 器官移植寻找供体的费用，或从器官捐献者体内摘除器官，运送器官及所有的相关行政费用。
13. 自愿剖腹产的费用或由先前自愿剖腹产导致的医疗必需的剖腹产费用，除非已购买常规生育保障。
14. 非病理性的妊娠终止、产前辅导班及与分娩无关的助产费用。
15. 新生儿护理，除非已购买常规生育保障。
16. 由男性及女性节育、绝育（或复通）直接或间接导致的费用。不孕症治疗（辅助受孕）可在已购买的不孕症治疗保障中予以赔付。不孕症治疗（辅助受孕）导致的妊娠并发症和常规怀孕费用可在已购买的常规怀孕保障中予以赔付。并受常规怀孕保障相关条款限制。
17. 对阳痿或其相关疾病的治疗及其治疗后果。
18. 直接或间接与变性相关的治疗及其治疗后果。
19. 性病或其它任何通过性传播的疾病及其相关疾病（艾滋病保障下列明的内容除外）。
20. 由心理治疗师或心理辅导者（除非由医生转介并直接监督）、家庭治疗师或丧亲辅导员提供治疗所产生的费用。
21. 对于学习障碍、多动症、注意力缺损症、言语矫治与生长发育、社会或行为问题的治疗（体检保障下列明的内容除外）。
22. 对酒精中毒、毒品或药物滥用或任何上瘾症状，以及由于上述滥用或上瘾而直接或间接导致的伤害或疾病而进行的治疗。对于居住于捷克共和国的会员，若不涉及违法行为，我们将按最低健康要求，对由服用药物或饮酒引发的意外事故所产生的治疗费用予以赔付。
23. 自杀或自杀未遂，或蓄意造成的自身身体伤害或疾病，或由于疏忽和鲁莽行为导致的身体伤害或疾病。

24. 由会员的违法行为、犯罪行为或协助犯罪行为直接或间接导致的伤害。
25. 会员不顾医学上的诊断意见而旅行所产生的费用。
26. 护送转院费用（除非经过我们的预授权）。空中、海上或山区救援费用（除非发生在经认可的滑雪区域或此类冬季运动胜地）。
27. 交通及住宿费用（除非在出行前已经获得我们的书面同意）。如果仅作为门诊治疗，则任何交通及住宿费用（包括租车费用）无法获得赔付。
28. 任何与失眠、睡眠障碍、睡眠窒息、疲劳、时差综合症、与工作压力有关的紧张状态，或相关疾病，而进行的治疗。
29. 无需处方即可购买的饮食补充剂及药物，包括但不限于维生素、矿物质，有机物质和婴儿口服配方食品等。然而，如果购买了常规怀孕保障，我们将支付产前处方维生素费用。
30. 医生、专科医生或合格护士的出诊费用，除非出诊前已经过我们的书面同意。
31. 从会员投保日或合同生效日（以较晚者为准）起 12 个月内，因妊娠并发症引起的费用，除非已经承保既往病史不咎或已购买了无等待期妊娠并发症保障。
32. 体外假肢（包括相关维护或安装）、助听器或其它医疗或非医疗设备，除非在已经购买的耐用医疗设备、假肢与矫形器材(DMEPOS)及听力或视力保障中另有规定。
33. 危险活动，包括职业运动和/或参加任何类别的赛车运动；登山，包括地下洞穴、山洞探险或勘探；超过 2500 米海拔的徒步旅行；非认可的场地滑雪或其他非认可场地冬季体育活动；北极南极探险。
34. 任何不在保障范围内或除外的项目或治疗所导致的并发症。
35. 自我治疗或由直系家庭成员提供的治疗，包括但不限于处方或非处方药物，诊断测试及外科手术。
36. 您保障计划中未列明的保障均不属于理赔范围。

重要释义

意外事故：指在本保险期间内，造成会员人身伤害的突发的、不可预见的、非本意的客观事件。

恐怖主义行为：包括但不限于使用武力、暴力和/或对于任何个人或团体进行威胁的行为，无论是单独行动或代表/联合任何组织/政府，以政治、宗教、意识形态或种族等目的或原因，还是以影响政府和/或使公众或公众的任何部门引起恐慌为动机。

急性病：指发病时间较短、结束时间明确，我们根据诊断意见或一般意见，认为可治愈的疾病。

诊断意见：任何医疗人员或专科医生提供的诊断结果，包括开处方或重复使用处方。

医疗器械：医生或者专科医生在外科手术中使用的医疗器械、植入物和设备。

保障地区：会员因罹患保险责任范围内的疾病，可接受治疗的地区或国家。

保障：本保险单覆盖的理赔范围，及在会员保险凭证的批单中载明的内容。

人身伤害：会员仅因意外事故而导致的断肢、残疾等身体伤害。

保险凭证：投保人为为会员所选的保险计划和保障组合、相关会员名单（包括其连带被保险人）等信息的清单。

慢性病：至少具有以下任一特征的疾病、病症或伤害：

- 持续的不定期发作，并且没有已知的治愈方法
- 复发或可能复发
- 具有持久性
- 会员需要接受康复治疗或特殊训练来缓和病症
- 需要长期接受监测、会诊、检测和化验。

共同保险：会员需承担的费用占实际发生医疗费用总额的比例。

合同生效日：指团体保险单上所载明的保险单首次生效的日期。

冲突/国内动乱：任何战争、侵略、外部敌对势力行为（无论是否宣战）、内战、叛乱、革命、起义、军事政变或篡权、兵变、骚乱、罢工、军事管制或戒严或推翻政府的行为或任何恐怖行径。

先天性疾病或畸形：指由于在妊娠至出生期间受影响而导致的遗传、物理或生物化学（代谢）缺陷、疾病或畸形（可能由遗传性疾病或怀孕期间感染引起），无论出生时是否显现。

连续转保条款：我们接受您目前保险公司的原始合同生效日，

并将应用于我们为您提供的保险单。我们将保留您目前保险公司提供的承保或特殊条款，如延期偿付或详细免责条款，您与我们签订的保单将受我们保险条款的制约。任何转保均不可获得升级保障。我们始终保留拒绝接受连续转保条款要求的权利，而无需提供任何原因或解释/包括附加性免责条款。

每次就诊的自付额：会员在直接结算网络内接受治疗时向医疗提供商支付的金额。每次就诊需支付一次自付额。

国籍：会员有效护照的签发国。

居住国家：会员在起始日期或续保日期当时的日常居住的国家（在保险期内至少居住 6 个月）。

理赔范围：团体保险计划提供给会员的保障内容。

投保日：保险凭证所载明的会员加入本保险单的日期。

日间留院病人：指在医院接受住院治疗但不过夜的会员。

扣除额：我们可能从向您支付的赔偿中扣除的金额，相当于在直接结算网络内接受治疗时向医疗提供商支付的自付额/共同保险。

牙科医生：获得权威部门执业资格证的在该国从事牙科治疗的人。

连带会员：被保险人的配偶、伴侣、和/或未婚子女（在合同生效日或续保日，不满 18 周岁，且与员工一起居住，或正在接受全日制教育，不超过 26 周岁）。伴侣应指丈夫、妻子或具有类似关系的、与员工长期共同居住的人员。所有连带会员均须载入保险凭证。

直系家庭成员：被保险人的配偶，子女，父母或兄弟姐妹。

直接结算：在医疗提供商已签约成为保险人的直接结算网络，或者保险人已经接受并同意进行一次性直接结算，会员的医疗费用账单将直接由保险人支付。

直接结算网络（仅适用于某些国家）：指能为会员治疗保障范围内的疾病并接受我们的直接结算安排的医疗供应商。会员仍需承担任何适用的自付额、共同保险、免赔额或扣除额，上述费用必须在治疗时直接向医疗服务供应商结算。

请注意：如果会员接受治疗的疾病不在保险单理赔范围之内，则该治疗费用须由会员承担，并且必须根据要求全额支付。如果未能按上述要求支付，我们会终止或取消您在团体计划项下的保险，且保险费不予退还。

药物敷料：是指由医生或者专科医生开具的基本药物、敷料和药剂，且只能在有处方的情况下获得。

选择性治疗：指医学上必要但非急诊所需的计划性治疗。

急诊：突发的、严重的、在意料之外的且需要立即进行医疗救治的急性病症或者伤害。

员工：由投保人聘用且具有团体保险资格的人员。

护送转院：如果事发地点无法获取治疗，将会员从事发地点转移到拥有适当医疗设施的最近国家而产生的费用，具体费用由医生或专科医生与我们的医疗顾问共同决定。所有机票仅限于经济舱。

免赔额：保险凭证上载明的，在赔付任意保障前，会员需自行承担的金额。

外籍人士：每个保险期内在本籍国之外生活或工作超过 6 个月的人员。

一般意见：相关专业机构就确立医学诊疗所给出的意见和/或已被公认的对于任何疾病或治疗的医学意见。

团体：至少由投保人的三名员工组成的团体。

团体保单管理员：被授权代表团体的人员。

遗传：先天继承而来的疾病或异常

临终关怀：提供姑息疗法而非临床治疗的机构。

医院：根据所在国家法律取得正式内科或外科医院执照的机构。

住院病人：以接受治疗为目的留住医院一晚或者更长时间的会员。

本国人：每个保险期间，在其有公民权的国家居住或工作时间超过六个月的人员。

疾病：任何疾病、病症或者伤害，包括精神疾病。

医生：在一所由世界卫生组织认可的医学院校学习并获得内科或者外科基本学位，并获得有关部门颁发的执照在该国家执业行医的人员。

医疗必需：合格的医生认为合适的、与诊断相符的医疗服务或治疗，且根据公认的医学标准，是不可被省去的，提供治疗后不会给被保险人的状况或生活质量带来不良影响。

会员/被保险人/您/您的：投保人所聘用的人员或受保的员工家属以及投保人所选团体保险保障内容。

亲属：配偶、子女、兄弟、姐妹、父母、配偶的父母及兄弟姐妹。

新生儿：出生时间不足 16 周的婴儿。

器官移植：因疾病更换重要器官（包括骨髓）。

门诊病人：在认可医疗机构接受治疗，但无需以住院或日间留院的方式接受治疗的会员。

姑息治疗：根据诊断或一般意见所提供的旨在暂时缓解症状的

治疗。姑息治疗不是用来治愈疾病的。本保险单中的姑息治疗包括肾透析。

保险期间：在保险凭证中载明。保险期间为从合同生效日或此后适用的续保日起，连续 12 个月的时间。

投保人：与我们签订保险协议的公司或团体。

保险单：团体健康保险单，它是我们与投保人签订的保险合同，且保单文件中详细规定了理赔范围。

保险单文件：构成投保人和我们之间合同协议的整套保单文件。包括申请表、团体构成表、保险凭证、会员手册和其他任何证明文件。

投保人：我们与之签约并其签发团体保单的实体。

单人病房：医院的单人居住病房。

医疗提供商：是指在相关国家中获得合法许可提供治疗的提供商。

医疗服务商网络：参与直接结算网络的治疗供应者。

合格护士：目前在其居住国家的任何法定护理注册机构的护士登记表或名单上登记的护士。

合理且惯常的费用：根据我们在具体国家、地区或区域的经验判断，对有效服务或治疗收取的平均金额，并由得到外科医生、医师、专科医生或政府卫生机构作为独立的第三方的证实。

康复治疗：协助在罹患疾病后需要物理治疗和独立生活帮助的会员，在医疗必须或实际可能的情况下，恢复到该疾病发生前的状态。

相关疾病：如果我们在经过一般诊断意见后确定任何疾病或伤害与其他疾病或伤害有关，或是由同一伤害或疾病引起的，这些疾病或伤害便属于相关疾病。

续保日：保险单生效日期的周年日。

双人病房：医院的双人居住病房。

专科医生：指在经认可的医疗机构内，具体从事某一专业科别（如内科，外科，妇科，儿科）诊疗的医生。

天然健全牙齿：是指意外事故发生前，稳固且功能健全，无腐烂及严重牙周疾病，维护良好的牙齿。

治疗：为治愈、缓解疾病而进行的手术、内科或其它治疗程序。

承保人：保单文件和保险凭证上载明的风险承担者和保障支付者。

病房：病人入住医院，与一人以上合住的病房。

我们/我们的：会员的保险凭证中载明的风险承担者和保障支付者，即华泰财产保险有限公司。

联络我们及投诉程序

如果有关于以下方面的问题，请随时与 Aetna 国际会员服务中心联系：

- 您的保险；
- 资格验证；
- 临床支持；
- 理赔；
- 与计划相关的一般问题；
- 有投诉请求如果要与 Aetna 国际会员服务中心联系，请拨打你的会员卡上注明的号码。您也可以按以下方式与我们联系：

地址：上海市黄浦区蒙自路 757 号歌斐中心,702 室,200023

电话：+86 400 881 1291

传真：+8621 6326 8525

电子邮箱：HTChinaServices@aetna.com

投诉处理程序概要

您的投诉将会：

- 立刻获得受理，并确定负责调查该投诉的人员。
- 获得公正、高效、彻底的调查，确保及时向您反馈调查进展。
- 得到公平、一致、及时的评估。

如果投诉与其它公司所提供的服务有关，我们将告知投诉人这一情况，并将投诉转交该公司处理。如果该投诉由我们和另一家公司共同负责，我们将告知投诉人这一情况，每家公司都会承担与投诉相关的责任并直接联系投诉人。

随时与 Aetna International 保持联络

欢迎访问www.aetnainternational.com

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Welcome to Aetna International

We're so glad to have
you with us

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Now that you are an Aetna International member, it is time to put your benefits to work. This handbook will help make it easy.

Aetna Health Hub

www.aetnachina.com.cn/CHNHH/index.do

What to do right now

The most important first step is to register for your Aetna Health Hub. The site gives you the tools you will need to manage your health benefits. You can register in just a few steps by visiting www.aetnachina.com.cn/CHNHH/index.do and clicking “Member” under the “Register” section. You will need to enter your name, date of birth, and the ID number on your Member ID Card.

You can use Aetna Health Hub to:

- Update your member details information, e.g. address;
- Review your Certificate of Insurance and plan details;
- Apply for Pre-authorisation (GOP);
- Submit and track your claims;
- Search your claim history;
- Find nearby doctors and hospitals;
- Review your health risk assessment;
- Browse a library of health topics.

Your Member ID Card

The Member ID Card is your key to quality health care. Make sure to keep the card in a safe place

You’ll be asked to present it whenever you receive health care treatment. You may also need to have it handy when registering for the website or calling the Member Service Centre.

Contact Us

It is as easy as calling the hotline number on the back of your Member ID Card, or writes to:

Address: Suite 702, 757 Meng Zi Road, Gopher Center,
Huang Pu District, Shanghai 200023 China

Postcode: 200023

Tel: +86 400 881 1291

Fax: +86 21 6326 8525

E-mail: HTChinaServices@aetna.com

ABOUT YOUR HEALTH PLAN

It is important that you take some time to understand your benefits coverage.

There are important documents on Aetna Health Hub that will help you understand your coverage better. To view these documents, log in to your Health Hub and click 'Your Account, Your Policy' then 'Policy Documents.' The documents located here will provide an overview of your coverage. You can also refer to page seven of this handbook for additional plan information.

Using the direct settlement network

You have access to our direct settlement network for easier admissions and payment. This network includes leading hospitals and clinics throughout the world. And it helps cut your out-of-pocket costs at the point of service since we'll pay all or part of the provider's fee directly.

Here is what direct settlement means for you:

- Easier claim submissions;
- Additional reimbursement and repayment choices;
- Lower out-of-pocket costs at the point of service;
- Verification of Benefit (VOB) letters sent directly to the treatment facility.

You can search our list of direct settlement providers online by logging in to your Health Hub. In addition, of course, you can always call our Member Service Centre for help at the number listed on the back of your Member ID Card.

If you'd prefer to visit a provider who is not in the direct settlement network, you can request a one-time direct-settlement, and if possible, we'll arrange it. Please keep in mind that not all medical facilities will accept direct payment from us. In these instances, you'll be required to settle the bill and submit a claim to us for reimbursement.

How to see a doctor

1. Find a direct settlement hospital provider by going online to your Health Hub and clicking 'DSN Guide'. You can also call us for help.
2. Schedule an appointment, identifying yourself or your family member as an Aetna member.
3. Show your Member ID Card when you go.

About pre-authorisation

You may need to obtain prior approval (pre-authorisation) before certain types of treatment. In these instances, it is important to start the process early to prevent delays or denial of your claims.

The best place to start is to talk with your provider about their process for pre-authorisation. In some cases, they may take care of it for you. If the provider instructs you to obtain it on your own, just give us a call at the number on your Member ID Card.

Here are some of the treatments that require pre-authorisation:

- Planned inpatient or day patient treatment in a hospital
- Any pregnancy or childbirth treatment (with the exception of routine pre-natal checks)
- Planned surgery
- Home nursing charges
- Planned MRI, PET and CT scans
- Infertility treatment (if purchased)
- Outpatient psychiatric
- Emergency evacuations

If you require emergency treatment, please do not delay treatment.

If you need hospital treatment

If you know you will need in-patient hospital treatment, it's important to communicate with us and your provider early to make sure you know exactly what your plan will cover. This will also help you avoid reimbursement delays later.

Before you're admitted to the hospital, you can contact us at the number on the back of your Member ID Card to provide details of the treatment. Or, if your hospital treatment is an unscheduled emergency, please contact us as soon as reasonably possible so we can authorise your coverage.

Medical Evacuation

If it's necessary for you to travel to get the medical attention you need, you'll have the support you need every step of the way. Our team will help coordinate your transportation and care.

We have partnerships with some of the world's most trusted medical evacuation and air ambulance providers, plus emergency travel assistance and security services. These services require pre-approval so it's important to contact us early to make sure your coverage is approved.

Help for your health needs

CARE (Care and Response Excellence) Team

If you have questions about your health care, you can call the CARE team to get answers. This team of clinicians is available 24/7/365 to support you pre-trip, post trip, and anytime in between.

Here are a few of the things you can get help with:

- Pre-trip planning;
- Coordinating routine and urgent medical care worldwide;
- Locating providers and specialists;
- Getting medical devices or prescription medications;
- Assistance with obtaining prescription medications and medical devices;
- Coordinating second opinions for complex cases;
- Coordination of care for return to home country after assignment completion;
- Discharge planning;
- Maternity management.

If you or a family member is managing a chronic health condition, or if you are pregnant, it is a good idea to talk with a CARE team clinician early on. They will be able to help make sure you get the care and medication you need no matter where you are in the world.

You can get in touch with CARE team by calling the number on the back of your Member ID Card, or click 'Contact CARE Team' in your Health Hub.

Get healthy, stay healthy

You have access to the health risk assessment- to help you get and stay healthy. This secure survey asks the right questions and recommends programmes and services to help you make positive health changes.

You can log in to your Aetna Health Hub and click 'Take the Assessment Today' to get started.

How to submit a claim

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

Please complete the claim form with Claimant's signature. One form shall be completed for each patient, for each medical condition treated. Besides claim form, please also provide the below materials:

- Original invoice (Fapiao) and charge breakdown (Medicines, exams, treatments and other expenses);
- Complete medical records, including but not limited to outpatient medical record, medical prescription, exam report. Please submit discharge summary if it is an inpatient claim.
- A copy of the payee's valid passport/ID card (front and back side) if the claim amount is above RMB10,000, USD 1,000 or equivalent.

How to submit a claim

You have the option to submit through Portal or electronically via Email if the following criteria are met:

- Treatment rendered outside of Mainland China, OR,
- Outpatient treatment received in Mainland China:
 - i. total amount of all Fapiao(s) not exceeding RMB 3,000 per specialty of treatment per day, and
 - ii. total amount of all Fapiao(s) not exceeding RMB 3,000 within a single submission

Visit www.aetnachina.com.cn/CHNHH/index.do and log in your Aetna Health Hub:

- Go to 'My Claim' → 'Submit New Claim';
- Enter all the required information following the steps and upload all the required document;
- Submit the claim.

We would suggest that you keep the original copy of you claim documents for future reference, as Aetna reserves the right to access the original copy of Fapiao upon request.

Any other claims that do not meet all of the above criteria should be submitted by post in hardcopies to the Aetna designated address at **Suite 702, 757 Meng Zi Road, Gopher Center, Huang Pu District, Shanghai.**

General conditions & exclusions

What are General Conditions and Exclusions?

“General Conditions” describe what we do as your health insurance company, as well as the rights and responsibilities of both you and us. “Exclusions” explain conditions or services not covered under your plan.

General Conditions

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 Chinese and 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 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 this contract, you must disclose the same to us and we shall not be liable to pay or contribute more than our rateable proportion.

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

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 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
- 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 on going cover and member safety.

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).
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. 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 gynecological 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 spas, 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, 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. 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 medical practitioner), a family therapist or bereavement counselor.
21. Treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy and developmental, social or behavioural problems (except as covered under the Wellness benefit , if purchased).
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-authorized 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 received in connection with insomnia, sleep disorders, sleep apnoea, fatigue, jet lag, work related stress or any related condition.
29. Dietary supplements and substances that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic substances, and infant formula given orally. We will however pay for prescribed pre-natal vitamins under the Routine Pregnancy benefit if purchased.
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 a Medical History Disregard 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 meters; 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 or non-prescribed medication, diagnostic tests and surgical procedures.
36. All benefits are excluded unless they appear on your benefits schedule.

Terms and 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, implants 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.

Coinsurance: 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 biochemical (metabolic) defect, disease, or malformation (which may be hereditary or due to an influence during gestation), and which may or may not be obvious at birth.

Continuous Transfer Terms: 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. This amount would be payable for each visit to the provider.

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 when making a claim for treatment received outside the direct settlement network, and which is equivalent to any copay or coinsurance that would normally be the responsibility of the member.

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 either because the provider is contracted to our direct settlement network or because we have received and agreed to make a one-time direct settlement.

Direct Family Member: Spouse, child, parent, sibling.

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 deductible applicable, which must be settled directly with the medical providers at the time of treatment.

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

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

Elective: Planned treatment that is medical necessary, but which is not required in an emergency.

Emergency: A sudden, serious, and unforeseen acute medical condition or injury requiring immediate medical care.

Employee: A person employed by the plan sponsor and eligible for cover under its group plan.

Evacuation: Where treatment is not available at the place of the incident, the costs incurred in moving a member from the place of incident to the nearest country with appropriate medical facilities, as determined by the attending medical practitioner or specialist in conjunction with our medical advisors. All airline tickets are limited to economy class.

Excess: The amount payable by a member in respect of expenses incurred before any benefits are paid under the policy, as specified in their certificate of insurance.

Expatriate: Any persons living or working outside their country of citizenship, for a period exceeding six months per period of cover.

General Advice: Advice from the relevant professional body to establish medical practice and/or established medical opinion in relation to any medical condition or treatment.

Group: An aggregate that is comprised of a minimum of three employees of the plan sponsor.

Group Administrator: A person authorised to act on behalf of the group.

Hereditary: A disease or disorder that is inherited genetically.

Hospice: A facility that provides palliative treatment and does not provide a cure.

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

Inpatient: A member who stays in a hospital bed and is admitted for one or more nights solely to receive treatment.

Local National: Any persons living or working in their country of citizenship, for a period exceeding six months per period of cover.

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

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.

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

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.

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. Huatai Property & Casualty Company Ltd.

How to contact us

If there is anything we can do to help you, we will do it. That is why we have multilingual service professionals available to you 24 hours a day, 7 days a week, and 365 days a year. You can call the Member Service Centre any time to get answers to benefits questions, assistance with claims, and access to the International Health Advisory Team of clinicians. It's as easy as calling the number on the back of your Member ID Card.

Complaints and appeals

It's our goal to provide you with the high quality service you expect and deserve. If we ever fall short, we hope you'll let us know. You can contact us any time to file a complaint or to appeal a decision we've made. Please provide your full name, birth date, and policy number.

Here's what we'll do:

- Respond to you quickly to let you know who is responsible for investigating your complaint
- Investigate the matter completely, efficiently and fairly
- and provide you with updates on progress

Respond to you within eight weeks to explain the status of your complaint or to provide a final response with the determination of the investigation

Here is how to contact us with a complaint or appeal:

Write to:

Asia-Pacific:

Suite 702, 757 Meng Zi Road, Gopher Center Huang Pu District, Shanghai 200023 China

T: +86 400 881 1291

F: +8621 6326 8525

E: HTChinaservices@aetna.com

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Important: This is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.

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