Quality health plans & benefits
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Financial well-being
Intelligent solutions

aetna®

华泰保险
Huatai Insurance Group

华泰全球至尊健康团体医疗保险计划

www.aetnainternational.com

46.02.446.0-CH B (10/16)

您可依靠我们的帮助来实现对您的业务及员工而言至关重要的目标。我们分担您对员工的关爱承诺，并将该承诺贯穿于我们工作的方方面面。所以我们与华泰财产保险有限公司携手，为您提供员工最期望并最值得拥有的卓越方案。

依托于强大实力及稳定性的保障

作为医疗福利的顶极供应商，我们共享传承160余年的专业实力。作为全世界最大最杰出的国际健康福利提供者之一，我们将此优势及稳定性扩展至全球范围已有三十余年。今天，我们为超过50万名全球会员提供援助。

我们在全球拥有700余名敬业的员工。

这包括下列区域：

- 大中华区（香港及上海）
- 东南亚（菲律宾马尼拉、新加坡、印度尼西亚雅加达）
- 中东（迪拜、阿布扎比、卡塔尔、科威特）
- 英国（伦敦、伯明翰）
- 美国（佛罗里达州坦帕市、俄亥俄州新奥尔巴尼市、宾夕法尼亚州布卢贝尔市、康涅狄格州哈特福特市）

实现优质医疗的承诺

以您的员工为中心的全球支持

除了我们遍布全球的强大网络外，您的员工还将获得我们实地工作团队提供的本地支持。这意味着无论您的员工身处何地，都可得到独一无二的照顾。

您的员工可获得：

- 由临床医师组成的国际健康顾问团队（IHAT）提供的一对一医疗援助
- 10万多家顶尖的医院及诊所组成的直接结算医疗网络
- 支持超过135种货币的索赔赔偿
- 可帮助员工更多关心和了解自身健康的网络及移动工具
- 每天24小时、每周7天、每年365天多种语言的会员服务帮助

总之，我们将超越自我，确保无论您的员工身处全球任何一处，都将得到很好地照顾。

专注于帮助您的事业

我们利用深厚的市场知识及本土专业经验帮助您管理成本及挑战、并使其最小化，这包括成为承担您员工健康职责的伙伴。我们将与您一起了解您的业务及全球员工的需求，以便我们能够提供积极主动的支持方案、清晰明了的指导意见以及有意义的解决办法，推进健康产出。

您可预期从我们这里获得：

- 对医疗费用的更好管理
- 积极有效的专有账户管理
- 简易且内置调控方案的合规规则
- 灵活便携的解决方案

我们的专业人员分担您对全球员工关爱的承诺。作为客户，您将得到我们全球网络提供的专业援助。

健康增值项目

健康是贯穿人们一生的漫漫长路，其旅程因人而异。本产品始于让会员专注于自身健康，在其旅途任一阶段——无论他们身体康健，还是存在疾病或受伤风险，或正在遭受慢性疾患，或正经历重大健康事件，我们都将支持他们。

因此，我们为会员开发了一项健康补充计划，它包括下列项目：

健康检查站®

健康检查站是一项具有多元文化的在线健康调查，此调查为会员提供有关其个人健康需要的信息，并促使会员做出持久性的积极改变。此工具还可有助于会员理解潜在的健康风险、并向他们提供促进健康行为的行动计划及信息。

我们还为超过100名成员的团体提供额外的健康检查服务，可包括不同水平的定制——从因地制宜的报告到完全量身定做的工具。欲了解更多信息，请咨询您的Aetna代表。

健康体检教育

无论您是身体健康并希望寻求额外健康生活的秘诀，还是罹患有慢性疾病，希望实现最佳健康状态，我们都会向您提供一系列的健康管理教育材料帮助您实现自己的健康梦想。

健康图书馆提供许多有用信息，包括下列健康主题：

- 哮喘
- 癌症
- 冠心病
- 怀孕及分娩
- 压力管理

国际医疗保健计划综述

提供创新灵活的解决方案

世界上没有相同的公司，这正是我们提供一系列不同类型保险计划和保障组合的原因，这样可以让您的健康保健投资最大化，并且在员工群体多样化的基础上控制成本。只需选择我们四种基本保险计划之一，然后在附加保障和保险金额菜单中进行选择。

这种灵活选择的优点就是雇主可以在同一保险单的基础上为不同的员工群体提供不同的保险计划。比如，他们可以为不同地区工作的员工分类，提供不同的保险保障等级，如为出行频繁的员工提供额外护送转院援助。

对于拥有50名或以上员工的企业，可选择提供额外灵活保障的自定义保险计划，包括听力和牙齿植入保障以及升级保障组合。

第1步：
选择基本保险计划和免赔额等级。

第2步：
选择您的保障组合。

第3步：
为您的保障组合定制理赔范围

协作型模式

我们经验丰富的团队将协助您选择出最适合您的业务模式和员工群体的计划类型和保障。

核心计划 | 锦绣计划 | 增强计划 | 精英计划

核心计划

综合全面的保障内容，包括但不限于：

- 住院和日间留院治疗保障
- 护送转院和交通保障
- 保障地区外的意外事故和急诊治疗
- 门诊护理（有保障金额上限）

锦绣计划

在核心计划保障的基础上，附加：

- 慢性疾病保障
- 门诊精神科治疗
- 增强型门诊护理保障（全额赔付）

增强计划

在锦绣计划保障的基础上，附加：

- 临终关怀
- 增强型医院现金保障
- 增强型慢性疾病保障
- 增强型替代疗法保障（20次）
- 增强型疫苗接种保障
- 增强型家庭护理保障

精英计划

在增强计划保障的基础上，附加：

- 紧急探望
- 提高年度最高总限额上限
- 扩大多种保障的理赔范围，包括：医院现金、慢性疾病、先天异常、耐用医疗设备、AIDS、临终关怀、替代疗法（30次）、护送转院和附加的旅行费用、遗体安葬和新生儿护理等保障。

降低费用*和/或升级保障的组合。

见7-9页完整列表，包括但不限于：

- 额外保障的紧急护送转院
- 不孕症治疗
- 住院床位限制*
- 出国就医交通费用
- 门诊就诊的自付额*
- 常规牙科治疗或牙齿修复和矫形治疗
- 常规怀孕
- 传统中医或印度医药
- 美国选择性治疗
- 视力护理
- 健康检查

许多选项都可以灵活改变。例如，我们在七个常规牙科治疗或牙齿修复和矫形治疗选项里提供了一系列的保障赔付限额——可以包括或不包括自负比例。

增值型健康管理方案

健康管理对人的一生都很重要，而且，每个人的人生旅途都是不同的。从让会员关注自身健康开始，并在他们的人生旅途中不断提供支持——无论他们身体健康，还是正处于疾病或受伤风险中，或正试图控制慢性疾病或正遭受着严重的健康问题。

为此，我们推出了Aetna全球健康网络——一套向会员免费提供的健康管理方案，它包括：

健康检查站®

健康检查站Wellness Checkpoint®是一项多元文化在线健康调查，它向会员提供关于他们个人健康所需的信息，促进他们做出长久的积极改变。该工具还帮助他们了解潜在的健康风险并且向他们提供促进健康行为的行动计划和信息。

我们还向超过100名会员的团体提供额外的健康检查服务，包括不同水平的客户化——从定制化报告到完全定制化工具。欲了解更多信息，请咨询您的Aetna代表。

癌症关怀和支持

我们采取量体裁衣的方法帮助癌症会员了解自身的疾病状况及查找有用的资源，即根据每个会员的具体健康状况提供专门针对该客户的服务。会员甚至可以和注册护士进行一对一的交流，护士将致力于帮助会员实现最佳健康状态。

健康管理教育

无论您是身体健康并希望寻找其它健康生活秘诀，还是罹患慢性疾病但希望实现最佳健康状态，我们都会向您提供一系列的健康管理教育材料帮助您实现自己的健康梦想。

Aetna国际健康管理中心为您提供许多有用的信息，包括许多健康主题，例如：

- 哮喘
- 癌症
- 冠心病
- 怀孕及分娩
- 压力控制

国际医疗健康保健计划对照

查看下述保障对照表，了解国际医疗保健计划的主要特点。

黑体词汇和短语具有特殊释义，请参见会员手册。

保单的期限为12个月，从投保日或随后的续保日起算。投保人须不断对保单进行评估，以确保所选保险计划能够持续满足员工的需求。

本保单摘要没有包括保单的所有条款；这些您可以在保障一览表、团体合同、保险凭证和会员手册中找到。

	核心计划	锦绣计划	增强计划	精英计划
年度最高赔付限额	每位会员每个保险期间最高赔付限额12,800,000元	每位会员每个保险期间最高赔付限额20,000,000元		每位会员每个保险期间最高赔付限额40,000,000元
住院、日间留院、急诊护理与诊断				
住院病人护理，重建手术与康复	全额赔付 i) 住院床位费取决于所选住院床位限额 ii) 康复护理全额赔付，每例疾病最高赔付天数为120天。			
保障地区外的意外事故与急救治疗	门诊治疗每例疾病最高赔付限额4,000元，且每例疾病免赔额650元。			
电脑断层、正电子电脑断层及核磁力共振扫描	全额赔付			
器官移植	全额赔付			
住院病人精神科治疗	每个保险期全额赔付（最高赔付天数为30天）			
牙齿意外受损	全额赔付			
医院现金保障	每例疾病每晚最高赔付限额1,000元，最多20晚		每例疾病每晚最高赔付限额1,400元，最多可赔付20晚	每例疾病每晚最高赔付限额2,000元，最多20晚
父母医院留宿	全额赔付			
疾病和慢性疾病管理				
肿瘤	全额赔付			
慢性疾病	无赔付	每位被保险人每个保险期间最高赔付限额40,000元	每位被保险人每个保险期间最高赔付限额120,000元	每位被保险人每个保险期间最高赔付限额240,000元
先天性疾病或畸形	每例疾病最高赔付限额800,000元			每例疾病最高赔付限额2,000,000
耐用医疗设备、假肢与矫形器材（DMEPOS）	每例疾病最高赔付限额8,000元			每个保险期间最高赔付限额80,000元
获得性免疫缺陷综合症（AIDS）	每个被保险人每个保险期最高赔付限额80,000元			每个被保险人每个保险期间最高赔付限额160,000元
临终关怀	无赔付		终生最高赔付限额200,000元	终生最高赔付限额400,000元
激素替代疗法	终生全额赔付，且最高赔付天数为18个月			
门诊与替代疗法				
门诊病人护理	每例疾病住院前后最高赔付限额13,600元，且在住院后最高赔付天数60天。 每例疾病替代疗法最多赔付10次，赔付限额同上。	全额赔付		
门诊手术	全额赔付			

	核心计划	锦绣计划	增强计划	精英计划
门诊精神科治疗	无赔付	每个保险期间最高赔付限额40,000元		
替代疗法	见门诊病人护理	每例疾病全额赔付，且最多赔付10次	每例疾病全额赔付，且最多赔付20次	每例疾病全额赔付，且最多赔付30次
疫苗接种	每个保险期最高赔付限额800元		每个保险期间最高赔付限额4,000元	
家庭护理	每例疾病全额赔付，且最高赔付天数为30天		每例疾病全额赔付，且最高赔付天数为28周	
护送转院和交通费用				
急诊交通费	全额赔付			
护送转院与额外交通支出 i) 交通费用 ii) 非医院住宿费用	i) 全额赔付 ii) 每人每天最高赔付限额1,200元，且每人每次护送转院最高赔付限额40,000元			每人每天最高赔付限额2,000元，且每人每次护送转院最高赔付限额80,000元
紧急探望	无赔付			以每个保险期间最高赔付限额24,000元作为标准
遗体转运及安葬	每个被保险人最高赔付限额68,000元			每位被保险人最高赔付限额120,000元
母婴护理				
妊娠并发症	全额赔付			
新生儿护理	每个保险期每个被保险人最高赔付限额800,000元，且住院最高赔付天数为90天			每个保险期间每位被保险人最高赔付限额2,000,000元，且住院最高赔付天数为180天
新生儿医院留宿	全额赔付			
减少费用选项				
中国大陆境内单人病房保障计划	全额赔付			
门诊就诊自付额 本保障内容只适用选择零免赔额的会员。	无赔付	每次就诊自付额或扣除额为120元(US$15)。 或 每次就诊自付额或扣除额为160元(US$20)。 或 每次就诊自付额或扣除额为240元(US$30)。		
住院床位限额	6个标准选项： 住院床位费每天限额从600元(US$75)到4,000元(US$500)不等			
升级保障选择				
无医疗转诊的替代疗法	无赔付	每位被保险人每个保险期间最高赔付限额8,000元/16,000元		
慢性疾病	无赔付	无其它选择——参见上述标准慢性疾病保障	全额赔付	
紧急探望	无赔付		参见上文所列保障——以每个保险期间最高赔付限额24,000元作为标准	
怀孕并发症-无等待期	全额赔付			
先天畸形-包括投保前已存在的先天畸形	3个选项从每例疾病最高赔付限额2,000,000元至全额赔付 全额赔付			
牙科1—常规牙科治疗	无赔付	14个标准选项： 从每个保险期最高赔付限额2,000元（有或无25%自负比例）到每个保险期最高赔付20,000元（有或无25%自负比例）		
牙齿保健2-牙齿修复治疗	无赔付	12个标准选项： 从每个保险期最高赔付限额4,000元（有或无25%自负比例）到每个保险期最高赔付限额20,000元（有或无25%自负比例）		

	核心计划	锦绣计划	增强计划	精英计划
牙齿保健3-齿科矫形治疗	无赔付	6个标准选项 : 从每个保险期最最高赔付4,000元 (有或无50%自负比例) 到每个保险期最高赔付8,000元 (有或无50%自负比例)		
额外保障护送转院 (转院到所选的国家)	全额赔付			
出国就医交通保障 对住院病人或日间留院病人进行的医疗必需的非紧急治疗所产生的出国交通费用 i) 交通费用 ii) 非医院住宿费用	i) 全额赔付 ii) 每天每人最高赔付限额1,200元 , 且每人每次护送转院最高赔付限额40,000元 或 ii) 每人每天最高赔付限额2,000元且每次护送转院最高赔付限额80,000元			
不孕症治疗 (要求最少10名员工)	无赔付		每位会员终生最高赔付限额200,000元	
常规怀孕	无赔付	8个标准选项 : 从每次怀孕最高赔付限额40,000元 (有或无20%自负比例) 到全额赔付 (有或无20%自负比例)		
传统中医和印度医药	无赔付	5个选项 : 从每次最高赔付限额250元且最多10次到每个保险期间最高赔付限额6,000元		
美国境内选择性治疗 i) 作为住院病人或日间留院病人在直接结算网络内接受的治疗 ii) 作为住院病人或日间留院病人在直接结算网络外接受的治疗 iii) 门诊病人治疗 国际医疗保健计划 (IHP) 不受《病人保护和平价医疗法案》(美国医疗改革) 限制 , 因此无法满足该法案对医疗保险理赔范围的规定。	无赔付	i) 全额赔付 ii) 每位会员每个保险期间最高赔付限额¥8,000,000且有50%自负比例 iii) 全额赔付		
视力保健	无赔付	每个保险期间一次眼睛检查且最高保障限额3个选项从人民币2,000元至6,000元		
健康检查选项 • 常规医疗检查与新生儿健康检查	每个保险期每个被保险人最最高赔付限额5个选项从人民币2,000元到12,000元			

	核心计划	锦绣计划	增强计划	精英计划
免赔额 保险单免赔额标准—在本保险单中选择的免赔额标准将适用于每例新疾病				
0元	标准	任选		
400元	不适用	任选		
800元	不适用	标准		
2000元	不适用	任选		
4000元	不适用	任选	不适用	
8000元	任选		不适用	
16000元	不适用	任选	不适用	
40000元	任选		不适用	

*以上常规牙科、牙齿修复、齿科矫形可以进行组合 , 并增加牙体种植治疗

医学核保

对于员工人数不足20 人的团体 , 所有员工都需填写完整的会员申请表。

我们的医学核保的标准方法是延期偿付 ; 但是投保人可根据自身情况为团体选择购买增强型承保条款。

延期偿付核保
我们的标准医学核保方式。

对于会员而言 , 个人在加入团体之日 (投保日) 已存在的疾病不在理赔范围之内 , 除非已接受治疗 , 而且投保后连续两年内未出现任何症状 , 并未接受过诊疗。慢性既往症的治疗不在本保险单的理赔范围之内。

全额医学核保
投保人可以让会员选择全额承保。

如果我们接受承保 , 我们可能增加附加条款和免责条款 , 并将这些条款载入保险凭证。

连续转保条款
适用于希望将其他保险转换为本保险的会员 , 可能需要额外缴纳保险费。

我们会接受会员原来保险单的初始投保日期 , 将其作为我们的保险单的开始日期。我们将保留原有的承保条款或特别附加条款 , 例如任何延期偿付或特殊除外责任 , 所有保险单条款仍将符合我们的保险单条款规定。任何连续转保将不被允许增加保障福利。我们保留随时拒绝连续转保的要求 , 并有可能无法提供理由。

既往病史不咎
适用于10名员工或以上的强制性团体保险计划。

既往症或投保之前已进行医疗咨询的疾病或相关症状的治疗也可纳入本保险的理赔范围。但是 , 其中不包括投保前的先天性疾病或畸形 , 除非会员加入保障时小于一周岁， 或已经购买”先天性疾病或畸形-包括投保前已存在的先天性疾病或畸形”的附加保障。

所有保障利益中的包含的等待期的要求将被移除。所有会员必须在30日投保资格期内登记加入。超出30日投保资格期内未投保的员工或员工家属将接受个人医学核保。

保险计划货币

本保险单仅限人民币 (元) 进行保费结算。

缴费频率

本保险单保费仅支持人民币银行转账 , 可按年缴 , 半年缴或季缴方式缴付。

按半年缴或季缴方式缴付保费将产生额外费用。

与员工建立联系

为便于您与您的员工及员工家属保持联系 , 我们提供了以下两种方式 :

- 电子会员包和邮寄会员卡
- 印刷会员包和会员卡复印件

被保险人年中调整

会员离开或加入计划时 , 投保人可通过以下两种方式进行会员调整 :

- **即付账单**--调整之后立即进行付款或退款处理。
- **年终调整**--我们将在年终时与您结算加减保费用。

投保人权利终止

本保险合同生效后 , 投保人可以在续保日后15日内以书面形式通知保险人解除保险单所包含的保障内容 , 或修改被保险人名单。如果投保人不计划续保， 保险人必须在投保人的续保日后15日内收到投保人不计划续保的书面通知。

如果投保人在其它时间以任何原因终止本保险合同 , 保险人均不予退还保费。

常见问题

问：**家庭成员是否也符合投保资格？**

答：与员工共同居住且未满18周岁，或在投保当日或续保当日还在接受全日制教育且未满26周岁的子女可以以家属的身份纳入保险范围。子女必须至少拥有一名法定父母或监护人，且他/她享有适用于保单各方的相同保障内容，否则无法纳入保障范围。对于人工受孕出生的家属需要提供一份健康申报书。

新生儿可在出生后纳入保险理赔范围内（有新生儿保障赔偿限额），但我们需要在新生儿出生后30天内收到书面通知并且在通知后30天内收到全额保险费。

问：**加入保险计划是否需要进行体检？**

答：不需要。只在少数情况下我们需要申请人提交一份由医生提供的健康报告，用以公正准确地进行核保。

问：**保险计划会涵盖会员入保前患有的疾病或伤害吗？**

答：如果您选择了延期承保，在成为会员的头两年中，保前已存在的疾病将不在理赔范围内。如果会员在这两年中未因该疾病出现任何症状、进行治疗或听取医疗意见，那么两年后所产生的费用将被纳入理赔范围。

您也可以申请加入连续转保条款 (CTT)。对于10个或以上员工的团体，您可以选择购买既往病史不咎计划。

问：**该计划是否包含在美国的选择性治疗？**

答：如果您选择购买了美国选择性治疗选项，该计划可覆盖这些治疗。这可以同锦绣计划、增强计划和精英计划一起购买。若投保人没有选择美国选择性治疗时，该计划只覆盖会员在美国发生的意外事故和紧急情况时产生的费用。在紧急情况发生时，如果会员在当地无法获得适当的治疗或护理，由此产生的交通费用将由护送转院保障所涵盖。

问：**保单免赔额是如何应用的？**

答：保单免赔额由会员承担。

问：**会员如何知道某种住院治疗是否在理赔范围之内？**

答：会员在计划进行住院治疗前，应取得我们的预授权。会员应联系Aetna International会员服务中心确认治疗是否在保险单理赔范围内。*

问：**会员如何提交索赔？**

答：每位会员会从一开始收到一张会员卡。该会员卡向会员提供了Aetna International会员服务中心的联系方式和在Aetna International 安全会员网站上注册所需信息。会员可选用其中一种提交索赔。

请确保您的理赔申请表填写完整，并请在治疗起180天之内提交。只能对保险期间内接受的治疗提出索赔。只有在保险到期或终止前产生的费用可获赔付。

*可直接向医院进行结算。会员手册中对索赔程序有详细说明。

附件：保障一览表详述

您的保险单可能包括以下保障内容。请参考您的保障计划以确认您保险单所涵盖的保障范围。

所有保障内容均适用本保障计划中规定的年度最高赔付限额及保险总限额，并适用相关医疗核保、会员保险凭证及我们的普通条款与免责条款。

所有在该地区接受治疗所产生的费用必须是医疗必须的合理且惯常的，且符合我们对地区平均医疗费用的标准。住院病人留宿费用仅限于标准单人病房，除非投保人选择其他床位限制。

住院病人、日间留院病人、急救护理和诊断

住院治疗：以住院或日间留院方式治疗所患伤病（包括对于慢性病急性发作的稳定治疗）产生的费用包括：

1) 住院床位费及膳食费；
2) 重症监护室使用费；
3) 由合格护士提供护理的收费；
4) 手术费及手术室费用；
5) 包括会诊在内的医生费用；
6) 包括病理检验，B超及X光检查在内的诊疗断及手术程序；
7) 整形重建手术（包括门诊治疗）费用，即因保险期间内发生的意外事故或疾病导致必需恢复自然功能或状态的整形重建手术，且相关治疗是在事故或疾病发生后的12个月内实施，且保险处于有效期内；
8) 由医生或专科医生开出的药物和敷料及医疗器械，包括传统中药；
9) 康复治疗（包括门诊治疗）费用，即3天或以上住院治疗后，在获认可的医院康复科进行的康复治疗，且必须是在出院后14天内进行。相关治疗必须是由医生推荐且由医生亲自指导。相关治疗包括特殊治疗室使用费、物理和/或语言矫治费，及其他通常由康复病房提供的服务所产生的费用。

保障地区范围外的意外事故与紧急治疗：

本保障内容适用于会员在美国短时旅行时，发生紧急的疾病或意外，须在医院急诊室接受紧急治疗而产生的医疗费用。相关伤病必须在当次旅行中首次出现，会员在旅行前从未出现任何相关症状，且未接受相关治疗或接受过任何相关医疗建议。

本保障内容也包括因会员在美国的短期旅行中遇到意外事故或紧急情况导致的普通门诊治疗。相关伤病必须在当次旅行中首次出现，会员在旅行前从未出现任何相关症状，且未接受相关治疗或接受过任何相关医疗建议。门诊治疗适用保障免赔额。

在美国境内遇到意外事故或紧急情况时，会员应在入住医院的急救病房前后尽快联系我们。

本保障内容不包括妊娠并发症和/或分娩并发症。

电脑断层、正电子电脑断层及核磁力共振扫描：以住院病人、日间留院病人或门诊病人接受的扫描检查。这些检查必须事先得到我们的授权。

器官移植：本保单所涵盖的器官移植包括：心脏、心/肺、肺、肾脏、肾脏/胰腺组织、肝脏、同种异体骨髓以及自体骨髓移植。

住院精神科治疗：在医院的注册精神病科接受的治疗。所有保障内容都具有条件性，即必须事先得到我们的授权且所有治疗都需在注册精神病医师的指导下进行。若进行此类治疗前没有得到我们的书面确认，我们将不负有赔付任何保障的责任。但是，由医师（而非精神病专科医生）初步会诊导致的精神病转诊费赔偿不需得到事先授权。

牙齿意外受损：因意外损坏天然健全牙齿后10天内在医院急诊室或者牙科诊所进行的治疗。后续随访治疗仅限一次就诊，且须在第一次治疗后的30天之内进行，并且事前须获保险人授权同意。因进食发生的牙齿意外损坏不在保险范围内。

医院现金保障：会员因发生保障范围内的伤病，接受住院治疗，未产生任何住院及治疗费用，保险人将启动现金保障赔付。若需申请本现金保障，会员应要求医院在理赔申请单上签名盖章。

本保障不适用于入住医院的意外事故和急救病房的情况。

本保障不适用保单免赔额。

父母医院留宿费用：年龄低于18周岁作为住院病人入住医院的会员需由父母一方或法定监护人进行陪护所产生的医院住宿费用。

疾病与慢性病治疗

肿瘤：以住院、日间留院或门诊方式进行的与癌症相关的医疗必需的诊断和治疗（包括姑息治疗）。

慢性疾病：慢性疾病（不含癌症）的常规检查、用于控制病情发展的药物和敷料、住院费，护理费、肾透析费、手术费及姑息治疗的费用。

癌症治疗费用的赔付属于肿瘤保障内容。

本保障不适用保单免赔额。

先天性疾病或畸形：对发生于会员的保障合同生效之后的先天性疾病或畸形，或保障合同生效前一年出生的连带被保险子女发生的先天性疾病或畸形的治疗。

耐用医疗设备、假肢与矫形器材（DMEPOS）：

赔付的保障内容包括：

i) 医疗必需的由治疗专科医生开具的耐用医疗设备，能对开具的处方药物和敷料产生疗效起到必要或辅助作用这不包括助听器费用（相关费用可在附加听力保障赔付 - 如选择）。
ii) 住院病人或日间留院病人接受治疗后的辅助器材费用，包括拐杖的购买或租用费用，以及轮椅初次购买或租用的相关费用。
iii) 外科手术后所需的体外假肢，包括支架及其固定、人工假眼以及人工假肢的初次购买和固定费用。
iv) 矫形器材,包括矫形鞋垫和矫形支架。

本保障内容不包括家庭家具类和适应类设备的提供、改装和固定。

艾滋病 (AIDS) : 因感染人类免疫缺陷病毒(HIV)或与其相关联的疾病 , 和/或包括获得性免疫缺陷综合症(AIDS)或AIDS关联综合征(ARC) 和/或其突变体或衍生变体在内的HIV相关疾病而产生的治疗费用。

保障范围仅限于此类疾病确诊前后的医生会诊费用、常规检查、药物和敷料 (试验类或未获药效证明类药品除外) 、住院和护理费。

一般免责条款中的性传播疾病除外不适用于本保障。

临终关怀 : 由临终关怀机构对诊断为晚期疾病的会员进行的临终关怀治疗。这些治疗包括 :

i) 姑息治疗以及其他急性和慢性症状的治疗。

ii) 在医生或专科医生指导下的医疗社区服务。

iii) 心理和饮食咨询。

iv) 由医生或专科医生进行的会诊或病例治疗服务。

v) 由合格护士提供的非全日制或间断性门诊护理服务 , 每天不超过八小时。

激素替代疗法 : 医生或专科医生对人为诱发造成和/或自然提前 (我们所说的自然提前是指40岁之前) 的女性停经进行的治疗 , 包括会诊费以及开具的处方药片、植入物或补片费用。

门诊及替代疗法

门诊治疗 : 医生、专科医生、会诊和护理费用 , 门诊费用包括诊断和外科检查 , 包括病理检查、X光射线检查、药物和敷料以及由医生或专科医生开具的医疗用具。由医生转介的物理治疗 , 对于每种疾病仅限为最多10次。如需进一步治疗 , 须提交由专科医生出具的病情复查报告。对此类治疗进行的首次索赔须提交一份转诊信/转诊报告。

精神科门诊治疗 : 对于门诊病人精神病治疗 , 包括专科医生会诊 , 所有治疗必须获得我们的事先授权 , 且必须一直在医生的直接指导下进行。若进行此类治疗前没有得到我们的书面确认 , 我们将不负有赔付任何保障的责任。但是 , 由医师 (而非精神病专科医生) 初步会诊导致的精神病转诊费赔偿不需得到事先授权。

门诊手术 : 该保障内容包括会员接受门诊手术所实际发生的手术费用。同时包括门诊内窥镜检查费用 , 包括胃镜检查、支气管窥镜检查、结肠镜检查、阴道镜检查 , 但不包括住院病人护理保障内容所包括的腹腔镜检查和腕关节镜检查。

替代疗法 : 根据医生或专科医生的转诊建议及直接指导下由注册脊医师、整骨医师、顺势疗法医师、足科医师和针灸医师进行的治疗。

接种疫苗 : 疫苗和预防接种 , 包括医疗必需的旅行疫苗接种

家庭护理 : 由专科医生建议的作为住院病人或日间留院病人接受治疗出院后马上接受的医院外护理。有关护理必须由合格护士进行 , 且不是出于家庭原因或方便考虑而进行的护理。

该保障范围内的所有治疗必须获得我们的事先授权。

护送转院和交通

急诊交通费 : 会员因急诊需要住院或日间留院 , 经医生或专科医生认为有医疗必要而使用最合适的交通工具护送会员往来医院接受治疗所发生的交通费用。

本保障内容不包括租车费用。

护送转院与额外交通支出 : 当发生紧急情况且当地没有所需治疗设施时,需将会员护送转院至由我们确定的最近的合适医疗机构 , 采取由我们确定的最适当的交通方式 , 让会员作为住院病人或日间留院病人入住医院。

护送转院需获得我们的书面同意 , 且在转院前需要主治医生或专科医生提供给我们相关证明文件 , 包括紧急情况发生当地无法进行所需治疗的确认书。

本合同保障内容不包括所有因怀孕及分娩而产生的护送转院费用 , 除非因属于怀孕并发症的保障内容而需要护送转院。也不包括在非认可的滑雪场所或类似的冬季运动场所产生的海空救援或登山救援费用。

本保障内容包括 :

i) 护送转院费用 , 包括因医疗必需 , 护送会员往来治疗的另外一名人员的交通费用。

ii) 当作为日间留院病人接受治疗时来往医疗点的交通费用。

iii) 当会员作为住院病人入住医院后 , 一名陪护人员往来医院探望该会员的交通费用。

iv) 会员及陪护人员返回居住国或护送转院前所在国家的经济舱机票费用。

v) 入住医院前后短期内在专科医生治疗情况下会员和陪护人员的非医院住宿费用。

紧急探望 : 当会员的亲属遭受意外事故被列入危急人员名单时 , 会员及其未成年子女 (16岁以下) 需要往来于该亲属国籍所在国或居住国的合理交通和住宿费用。

遗体转运及安葬 : 会员发生保险责任范围内的伤病导致身故 , 会员遗体或其骨灰运至国籍所在国或居住国而产生的交通费用 , 或按照死亡发生地的惯例进行合理安葬或火葬的费用。

合理的安葬或火葬的费用包括 :

- 重开坟墓和安葬费用 , 或
- 新开坟墓和安葬费用 , 包含安葬专有权费 , 或
- 其中火葬费用包括 :

1. 火葬费用
2. 医生证明费 用
3. 火葬前必须 除去的心脏起搏器或其它医疗设备的费用

但不包括其它的葬礼费用 , 例如 :

- 葬礼承办者的费用
- 鲜花
- 发放死者现金、储蓄和财产所需的文件费用

-会员往返葬礼的路费 , 包括 :

1. 安排葬礼 , 或
2. 参加葬礼

母婴护理

妊娠并发症：女性被保险人在产前阶段或分娩时发生的如下疾病，需要获认可的妇产科专科医生进行治疗而产生的费用，或因妊娠并发症导致的产后六周内所需的检查费用：异位妊娠、妊娠期糖尿病、葡萄胎、流产（实际流产或先兆流产）、先兆子痫、产程停滞或死胎、产后出血及胎盘胎膜留滞。因人工受孕导致的并发症，包括但不限于早产或多胎等不属于本保障内容。
本保障内容的赔付须在合同生效日或投保日（以较晚时间为准）起12个月后进行。

新生儿保障：出生后30天内因新生儿发生急性疾病而接受的住院治疗。本保障内容不包括因人工受孕导致的并发症，包括但不限于，早产或多胎。本保险不包括新生儿发生的先天畸形，相关赔付属于先天性疾病或畸形的保障内容。

新生儿必须加入保障计划，本保障内容方可生效。在30天新生儿保障期间后，除非出生后30天内发生或出现疾病，会员的连带被保险人将被纳入保险范围，但需在出生 30内提交书面告知并在支付到期日30天内支付所有保费。若连带被保险人是在不孕症治疗（人工受孕）后出生，还需提供相关健康声明。

新生儿医院留宿：新生儿(出生不超过16周)因母亲(会员)分娩后在医院接受住院治疗而在医院留宿的费用。

降低保费的可选保障

门诊就诊自付额：当门诊就诊发生在保险人的医疗提供商网络范围内，会员需要承担该自付额。如果就诊仅发生在医疗提供商网络范围之外，或会员自行支付医药费用并申请理赔时，每次就诊需要另行扣除一定的费用（扣除额).

此选项不适用于在中国大陆地区公立/政府医院内接受的医疗服务。

仅当治疗发生在中国大陆以外地区医院时， 自付额/扣除额以保障一览表所列美金金额为准。

门诊就诊根据会员的保障计划内容及保额，可包括以下内容。

i) 妊娠并发症
ii) 先天性疾病或畸形
iii) 电脑断层扫描和核磁共振扫描
iv) 激素替代疗法（HRT）
v) 肿瘤
vi) 门诊治疗
vii) 门诊精神病治疗
viii) 门诊手术

住院床位限额：住院床位费仅限于所选住院床位限额。如入住医院重症监护病房，住院床位费用将全额赔付。

此选项不适用于在中国大陆地区公立/政府医院内接受的医疗服务。

仅当治疗发生在中国大陆以外地区医院时， 自付金额以保障一览表所列美金金额为准。

中国单人病房限制：该保障仅适用于中国大陆居民。当在中国大陆之外以住院病人或日间留院病人接受治疗时，保障内容仅限于双人病房及其相应费率。

保险升级的其他组合

替代疗法—无需转介：由注册脊医师、整骨医师、顺势疗法医师、足科医师或针灸师实施的替代疗法。

先天性疾病或畸形-包括投保前已存在的先天性疾病或畸形：先天性疾病或畸形的治疗。

妊娠并发症-无等待期女性被保险人在产前阶段或分娩时发生的如下疾病，需要获认可的妇产科专科医生进行治疗而产生的费用，或因妊娠并发症导致的产后六周内所需的检查费用：异位妊娠、妊娠期糖尿病、葡萄胎、流产（实际流产或先兆流产）、先兆子痫、产程停滞或死胎、产后出血及胎盘胎膜留滞。因人工受孕导致的并发症，包括但不限于早产或多胎等不属于本保障内容。

牙齿保健1-常规牙科治疗：牙科医生进行常规牙科手术治疗产生的费用。常规牙科治疗包括：

- 检查
- 洗牙
- 普通复合物补牙
- 简单非手术拔牙

本保障内容不包括牙齿正畸治疗、牙齿复杂修复治疗及牙体种植。本保障内容不适用保单免赔额。

具有6个月的等待期，时间自购买本保障或会员投保日算起（以较晚时间为准）。

牙科2——复杂修复性牙科治疗：该保障涵盖牙科医生费用以及与下述具体治疗程序相关的费用，包括：

- 拔除阻生牙、掩埋牙或未萌牙
- 牙根切除
- 固体牙瘤切除
- 根尖切除术
- 新装或修复牙桥托
- 新装或修复齿冠
- 牙根管治疗
- 新装或修复上或下部假牙
- 拔除智齿（在医院或牙科外科诊所进行，由牙科医生、专科医生或口腔医生操作）

本保障内容不包括牙齿正畸治疗、常规牙齿治疗及牙体种植。

本保障不适用保单免赔额。

具有6个月的等待期，时间自购买本保障或会员投保日算起（以较晚时间为准）。

牙齿保健3-齿科矫形治疗：本保障内容必须和常规牙科治疗或牙齿修复治疗一起购买，包括牙科医生进行牙科手术做的齿科矫形治疗的费用及相关收费。本保障内容仅限于18岁及以下的会员。本保障不适用保单免赔额。

具有6个月的等待期，时间自购买本保障或会员投保日算起（以较晚时间为准）。

牙科4——植牙：牙体种植的治疗和费用。

保单免赔额不适用于本保障内容。

具有6个月的等待期，时间自购买本保障或会员投保日算起（以较晚时间为准）。

牙齿保健5-牙科常规与修复治疗：牙科常规治疗包括牙科医生进行常规牙科手术治疗产生的费用。常规牙科治疗包括：

- 检查
- 洗牙
- 普通复合物补牙
- 简单非手术拔牙

牙科修复涵盖进行下列治疗所产生的牙医收取的费用和附带费用。

- 拔除阻生牙、掩埋牙或未萌牙
- 牙根切除
- 固体牙瘤切除
- 根尖切除术
- 新装或修复牙桥托
- 新装或修复齿冠
- 牙根管治疗
- 新装或修复上或下部假牙
- 拔除智齿（在医院或牙科外科诊所进行，由牙科医生、专科医生或口腔医生操作）

本保障内容不涵盖牙齿正畸治疗及牙体种植。

本保障不适用保单免赔额。

具有6个月的等待期，时间自购买本保障或会员投保日算起（以较晚时间为准）。

牙齿保健6-牙科常规、修复与矫形治疗：牙科常规治疗包括牙科医生进行常规牙科手术治疗产生的费用。常规牙科治疗包括：

- 检查
- 洗牙
- 普通复合物补牙
- 简单非手术拔牙

牙科修复涵盖进行下列治疗所产生的牙医收取的费用和附带费用：

- 拔除阻生牙、掩埋牙或未萌牙
- 牙根切除
- 固体牙瘤切除
- 根尖切除术
- 新装或修复牙桥托
- 新装或修复齿冠
- 牙根管治疗
- 新装或修复上或下部假牙
- 拔除智齿（在医院或牙科外科诊所进行，由牙科医生、专科医生或口腔医生操作）

齿科矫形治疗包括牙科医生对18岁及以下的会员进行牙科手术做的齿科矫形治疗的费用及相关收费。

本保障内容不涵盖牙体种植。

本保障不适用保单免赔额。

具有6个月的等待期，时间自购买本保障或会员投保日算起（以较晚时间为准）。

牙齿保健7-牙科常规、修复、矫形与牙体种植治疗：牙科常规治疗包括牙科医生进行常规牙科手术治疗产生的费用。常规牙科治疗包括：

- 检查
- 洗牙
- 普通复合物补牙
- 简单的非手术拔牙

牙科修复保障包括牙科医生的费用以及与下述具体治疗程序相关的成本费用：

- 拔除阻生牙、掩埋牙或未萌牙
- 牙根切除
- 固体牙瘤切除
- 根尖切除术
- 新装或修复牙桥托
- 新装或修复齿冠
- 牙根管治疗
- 新装或修复上或下部假牙
- 拔除智齿（在医院或牙科外科诊所进行，由牙科医生、专科医生或口腔医生操作）

齿科矫形治疗包括牙科医生对18岁及以下的会员进行牙科手术做的齿科矫形治疗的费用及相关收费。

植牙包括牙体种植治疗和相关收费。

本保障不适用保单免赔额。

具有6个月的等待期，时间自购买本保障或会员投保日算起（以较晚时间为准）。

门诊直接结算网络 - 零免赔额：当会员选择在直接结算网络内的医院/诊所接受门诊治疗，会员无需支付免赔额。当门诊治疗发生在直接结算网络范围外时，则需支付免赔额。

下述关于门诊会诊的保障内容可以进行赔付，但须包括在您的保健计划中，并具有相应所选定的赔付限额。

i) 妊娠并发症
ii) 先天性疾病或畸形
iii) 电脑断层扫描和核磁共振扫描
iv) 激素替代疗法（HRT）
v) 肿瘤
vi) 门诊治疗
vii) 门诊精神病治疗
viii) 门诊手术

额外保障护送转院：当发生紧急情况且当地无法提供所需治疗时，需对会员进行护送转院，至由保险人确定的最近的合适医疗机构，并以住院或日间留院方式入住医院而产生的费用。转院地点需由保险人确定的最近最合适的位于会员居住国、国籍所在国或会员选定国家的医疗机构。产生的费用包括医疗必需的会员转移途中的陪护人员（一位）费用。

护送转院需我们的书面同意，且在转院前需要相关医生或专科医生提供给我们相关证明文件，包括紧急情况发生当地没有所需治疗的确认书。会员所选国家仅限于具有合适的医疗设施且我们认为具有合适医疗能力的国家。若根据我们的医疗顾问的咨询所选国家不具有可操作性或所选国家对疾病的治疗不具有合适的设施，则所作选项无效。我们的医疗顾问将决定护送转院最适当的护送转移方式。

本保障利益不涵盖指定滑雪场地或同类冬季运动场地之外发生的任何海空救援或山区救援所产生的费用，也不涵盖怀孕并发症保障范围以外的所有分娩费用，也不涵盖未购买或在会员保障计划中未予以列明的美国选择性治疗。

出国就医交通保障：当需要医疗必需的非紧急治疗且当地没有所需治疗时，需对被保险人进行护送转移至保障地区内最近的具有能力的医疗中心产生的费用，以让被保险人作为住院病人或日间留院病人入住医院（不包括怀孕并发症保障范围以外的一切分娩费用），和/或以寻求医疗必需的住院、日间留院或门诊治疗。本保障所涉及的赔付需在护送转移前得到我们的书面同意，且需要相关医生或专科医生提供给我们相关证明文件，包括紧急情况发生当地没有所需治疗的确认书。本保障的涵盖范围包括：

i) 护送转院费用（仅限于经济舱机票），包括医疗必需的会员转移途中的陪护人员（一位）费用。

ii) 当作为日间留院病人接受治疗时来往医疗点的交通费用。

iii) 作为住院病人的陪护人员往来医院探望会员所产生的费用。

iv) 会员和陪护人员返回居住国或护送转院发生国的经济舱机票。

v) 入住医院前后短期内会员由专科医生看护情况下会员和陪护人员的非医院住宿费用。

听力保障：每一保险年度限一次的听力检查；以及助听器的费用。

本保障不适用保单免赔额。

不孕症治疗（最少需10位员工）：通过口服或注射不孕症药剂促进排卵，人工授精和高级辅助生殖技术（ART）治疗，以及体外胚胎授精移植（IVF）。

本保障需要在进行任何形式的治疗前获得事先授权许可。

下述免责条款适用：

- 夫妇一方已经做过节育手术的，且无论是否接受过复通手术。
- 月经周期第三天FSH水平等于或高于19 mIU/ml或克罗米芬水平显示阳性的女性。
- 涵盖的费用包括：捐献精子的购买和储存，因获取或转移捐献卵子所需的对捐献者的护理，以及低温保存胚胎所需的低温储藏。
- 针对在加入高级辅助生殖技术（ART）不孕症计划之前至少12个周期没有进行供体精子人工受精（如果会员的年龄为35岁或更大则为6个周期）的妇女而进行的先进生殖技术。
- 任何与妊娠载体（代孕父母）有关的费用，无论是因为会员或妊娠载体而产生。

常规怀孕：与自然怀孕和分娩有关的费用，包括不孕症治疗（辅助授精）后进行的正常分娩，自愿剖腹产以及之前因非医疗原因剖腹产导致的医疗必需的剖腹产费用。本保障涵盖产前及产后六周的检查费用、医生开具的产前维他命和分娩费用，包括合格的助产士费用。不孕症治疗（辅助授精）后所有与怀孕和分娩并发症有关的费用均属于本保障范围。

本保障范围还包括新生儿相关费用，但仅限如下项目：
一次新生儿体格检查；
维生素K，B型肝炎和卡介苗疫苗接种；
包皮环切术；
血常规检查，先天性甲状腺疾病检查，PKU和G6PD检查；
一次听力检查；
最高四个晚上的新生儿医院留宿费用（当其母亲产后因非并发症原因住院期间）。

本保障不适用保单免赔额。

具有12个月的等待期，时间自购买本保障之日或会员投保日算起，以较晚的为准。出生24小时之后，新生儿需在出生后30天内加入本保障，方可按照保障条 款获得保障利益。

传统中医药或印度医药：该保障涵盖由注册的传统中医或印度医师实施治疗的费用。

本保障不适用保单免赔额。

美国选择性治疗：

i) 在直接结算网络内进行的住院病人或日间留院病人治疗

ii) 在直接结算网络外进行的住院病人或日间留院病人治疗（涉及50%的自负比例）

iii) 门诊治疗

所有计划中的住院和日间留院治疗必须在治疗进行前告知我们。

国际医疗保健计划（IHP）不适用于美国的“病人保护与医疗平价法案”（美国医疗改革法案），因此本计划的健康保险保障范围不适用于该法案。

视力保健：每个保险期间内一次常规视力检查以及当会员医疗处方变更时所需的视力辅助工具的购买所产生的费用，包括处方要求的眼镜或隐形眼镜。

本保障不适用保单免赔额。

健康检查选择1：本保障理赔范围涵盖：

i) 常规医疗检查和相关检测。这些常规检查/检测包括：常规血液和胆固醇检测、身高/体重指数检测、静态血压检测、尿检、心脏检查、运动心电图（ECG）、其他主要器官功能检测以及X光线胸透视。

ii) 由医生或专科医生推荐的新生儿 出生24小时后，至两周岁前 的健康检查，包括身体检查、测量、感官检查、神经精神学评估、发育检查，以及遗传和代谢检查、免疫接种、尿检、结核检测和红细胞压积、血红蛋白和其它血液检测，包括镰状红细胞性血红蛋白病筛检。

本保障不适用保单免赔额。

健康检查选择2：本保障理赔范围涵盖：

i) 双侧乳房X线摄片/常规的妇科检查，包括宫颈涂片检查。

ii) 睾丸/前列腺检查/前列腺特异性抗原检测/直肠指检

iii) 常规医疗检查和相关检测。这些常规检查/检测包括：常规血液和胆固醇检测、身高/体重指数检测、静态血压检测、尿检、心脏检查、运动心电图（ECG）、其他主要器官功能检测，以及X光线胸透视。

iv) 由医生或专科医生推荐的新生儿 出生24小时后，至两周岁前的健康检查，包括身体检查、测量、感官检查、神经精神学评估、发育检查，以及遗传和代谢检查、免疫接种、尿检、结核检测和红细胞压积、血红蛋白和其它血液检测，包括镰状红细胞性血红蛋白病筛检。

本保障不适用保单免赔额。

健康检查选择3 预防筛检：为具有癌症高风险的会员提供的预防筛检健康检查，高风险可能因为具有家族性息肉病或遗传性非息肉病性直肠癌、慢性炎症性肠病家族史、乳房癌、卵巢癌、子宫内膜癌、直肠癌或息肉病家族史，或与生活背景、种族或生活习惯等因素有关，因而与会员接触的医生认为他或她具有高风险，应该做些筛检检测，包括结肠镜检查、钡剂灌肠或其他可行的最可靠、最有效的筛检检测。

本保障不适用保单免赔额。

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，请拨打您的会员卡上注明的号码。您也可以按以下方式与我们联系：

亚太地区：

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：Email: 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。

全球化战略，本土化经营——我们在全球各个地方随时为您服务

Aetna能够让您和您的员工得到一流的保障和服务。

您准备好领略Aetna的卓尔不同吗？

欲了解更多信息，请即刻联系我们

亚太地区：
+400 880 8891
agbsalesshanghai@aetna.com

随时与Aetna国际保持联络

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You can count on us to deliver on the goals that matter most to your business and your employees. We share your commitment to caring for your employees and it comes across in everything that we do. That's why we've come together with Huatai Property & Casualty Company Ltd. to deliver the exceptional solutions your employees expect and deserve.

Benefits backed by strength and stability

We share in the heritage of more than 160 years of expertise as a leading provider of health care benefits. For more than three decades, we've extended that strength and stability across the globe as one of the world's largest and most prominent providers of international health benefits. Today, we support more than 500,000 members worldwide.

WE HAVE MORE THAN 700 DEDICATED EMPLOYEES WORLDWIDE.

This includes locations in:

- Greater China (Hong Kong and Shanghai)
- Southeast Asia (Manila, Philippines; Singapore, and Jakarta, Indonesia)
- Middle East (Dubai, Abu Dhabi, Qatar, and Kuwait)
- United Kingdom (London, England; Birmingham, England)
- United States (Tampa, Florida; New Albany, Ohio; Blue Bell, Pennsylvania and Hartford, Connecticut)

Delivering on the promise of quality health care

Global support that centres on your employees

Your employees will have the local support of our on-the-ground teams along with the global strength of our worldwide network. This means they will have access to exceptional care no matter where they are.

Your employees will have access to:

- One-on-one health care support from our International Health Advisory Team (IHAT) of clinicians
- A direct settlement provider community of more than 100,000 leading hospitals and clinics
- Claims reimbursement in over 135 currencies
- Web and mobile tools that help employees play a greater, more informed role in their health
- 24x7x365 multilingual member service support

In short, we'll go above and beyond to make sure that your professionals are well cared for, wherever they are in the world.

A focus on helping your business

We leverage our deep market knowledge and in-country expertise to help you manage and minimise costs and challenges. This includes being a partner who takes responsibility for the health and well-being of your employees. We'll work with you to understand your business and the needs of your global workforce so we can provide proactive support, clear guidance and meaningful solutions that drive healthy outcomes.

Here's what you can expect from us:

- Better management of medical costs
- Dedicated, proactive account management
- Simplified compliance with built-in regulated solutions
- Flexible, portable solutions

As our customer, you'll gain the support of our global network of professionals who share your commitment to caring for your employees around the world.

Value-added wellness programmes

Wellness is a lifelong path, and the journey is different for each individual. It begins with getting members engaged in their own well-being and supporting them wherever they are on their journey — whether they are healthy, at risk for disease or injury, managing a chronic condition or experiencing a major health event.

With this in mind, we've developed a complimentary wellness offering for members, which includes the following programmes:

Wellness Checkpoint®

Wellness Checkpoint is a culturally diverse, online health survey that provides members with information about their personal health needs and motivates them to make lasting positive changes. The tool can also help them understand possible health risks, and provides an action plan and information that encourages healthy behaviours.

We also offer additional tiers of Wellness Checkpoint for groups over 100 members, which can include varying levels of customisation — from tailored reporting to a fully-bespoke tool. Please consult with your Aetna representative for additional information.

Health and wellness education

Whether employees are healthy individuals looking for additional healthy lifestyle tips — or have a chronic condition and want to learn how to reach their optimal state of health — we offer an array of health and wellness education materials to aid them in their efforts.

The health library provides helpful information, including topics such as:

- Asthma
- Cancer
- Coronary artery disease
- Maternity
- Stress management

Group Health Insurance Plan Overview

An innovative, flexible offering

No two companies are alike. That's why we offer a range of plans and optional benefits so you can maximise your health care investment and manage costs based on your varied employee populations. You can select from one of four base plans, then choose from a menu of additional benefits and sums insured.

This means you have the flexibility to provide different plans for different groups of employees within the same policy. For example, you can set up different categories for employees working in different regions, which provide different levels of cover, such as including extended evacuation assistance for employees who travel more frequently than others.

For qualifying groups of 50 or more employees, you can benefit from the additional flexibility of a custom plan that includes additional benefits and increased limit options.

STEP 1:

Choose a base plan and excess level.

STEP 2:

Choose your optional benefits.

STEP 3:

Tailor the level of cover for your optional benefits.

A collaborative approach

Our team is committed to working with you to identify the plan type and benefits that are best for your business and the employees you're looking to cover.

Core | Essential | Plus | Elite

Core

A comprehensive range of benefits, including, but not limited to:

- Inpatient and day patient treatment benefits
- Evacuation and transportation benefits
- Accident and emergency treatment outside area of cover
- Outpatient care (with a capped benefit)

Essential

Core benefits, plus:

- Chronic conditions benefit
- Outpatient psychiatric treatment
- Increased outpatient care benefit (fully covered)
- Alternative Treatment

Plus

Essential benefits, plus:

- Hospice care
- Increased hospital cash benefit
- Increased chronic conditions benefit
- Increased alternative treatment (20 sessions)
- Increased vaccinations and inoculations benefit
- Increased home nursing benefit

Elite

Plus benefits, plus:

- Compassionate emergency travel
- Increased maximum annual aggregate limit
- Increased level of cover for a number of benefits, including: hospital cash, chronic conditions, congenital anomalies, durable medical equipment, AIDS, hospice care, alternative treatment (30 sessions), evacuation and additional travel expense, mortal remains and new born care

Optional benefits either reduce costs and/or upgrade cover.*

See pages 6 – 10 for a full list of options, which include, but are not limited to:

- Extended emergency evacuation
- Infertility treatment
- Inpatient bed limit*
- Out of country transportation
- Outpatient consultation copay per visit*
- Routine or restorative dental and orthodontic options
- Routine pregnancy
- Traditional Chinese or Ayurvedic medicine
- USA elective treatment
- Vision care
- Wellness options

Many of the options can be flexed. For example, we offer a range of benefit limits within our seven routine or restorative dental and orthodontic options — with the ability to include or exclude a coinsurance.

Group Health Insurance Plan benefits comparison

To find out about the key features of the International Healthcare Plan, please see the following comparative benefits schedule.

This will be a 12 month policy starting from the date of entry or any subsequent renewal date, as applicable. It is the responsibility of the policyholder to continually review your policy in order to ensure that the plan selected continues to meet the needs and requirements of your employees.

This policy summary does not contain the full terms of the policy; these can be found in the benefits schedule, group contract, certificate of insurance and member handbook.

	Core	Essential	Plus	Elite
Maximum annual aggregate limit	A maximum of ¥12,800,000 per **member** per **period of cover**	A maximum of ¥20,000,000 per **member** per **period of cover**		A maximum of ¥40,000,000 per **member** per **period of cover**
Inpatient, day patient, emergency care and diagnostics				
Inpatient care, reconstructive surgery and **rehabilitation**	Covered in full i) Accommodation is subject to any selected inpatient bed limit ii) **Rehabilitation** is covered in full up to 120 days per **medical condition**			
Accident and **emergency treatment** outside **area of cover**	**Outpatient treatment** is limited to ¥4,000 per **medical condition** and subject to an **excess** of ¥650 per **medical condition**			
CT PET and MRI scans	Covered in full			
Organ transplant	Covered in full			
Inpatient psychiatric **treatment**	Covered in full (up to 30 days) per **period of cover**			
Accidental damage to teeth	Covered in full			
Hospital cash	Up to ¥1,000 per night for a maximum of 20 nights per **medical condition**		Up to ¥1,400 per night for a maximum of 20 nights per **medical condition**	Up to ¥2,000 per night for a maximum of 20 nights per **medical condition**
Parental accommodation	Covered in full			
Disease and chronic condition management				
Oncology	Covered in full			
Chronic conditions	No **cover**	Up to ¥40,000 per **insured person** per **period of cover**	Up to ¥120,000 per **insured person** per **period of cover**	Up to ¥240,000 per **insured person** per **period of cover**
Congenital anomalies	Up to ¥800,000 per **medical condition**			Up to ¥2,000,000 per **medical condition**
Durable medical equipment, prosthetic and orthotic supplies (DMEPOS)	Up to ¥8,000 per **medical condition**			Up to ¥80,000 per **period of cover**
AIDS	Up to ¥80,000 per **insured person** per **period of cover**			Up to ¥160,000 per **insured person** per **period of cover**
Hospice care	No **cover**		Up to ¥200,000 per lifetime	Up to ¥400,000 per lifetime
Hormone replacement therapy	Covered in full up to 18 months per lifetime			

	Core	Essential	Plus	Elite
Outpatient and alternative treatments				
Outpatient care	Up to ¥13,600 per **medical condition** prior to hospitalisation and up to 60 days immediately following hospitalisation. Alternative **treatment** up to 10 sessions in aggregate per **medical condition**, and subject to the **benefit** limit above.	Covered in full		
Outpatient surgery	Covered in full			
Outpatient psychiatric **treatment**	No **cover**	Up to ¥40,000 per **period of cover**		
Alternative **treatment**	See **outpatient** care	Covered in full up to 10 sessions in aggregate per **medical condition**	Covered in full up to 20 sessions in aggregate per **medical condition**	Covered in full up to 30 sessions in aggregate per **medical condition**
Vaccinations and inoculations	Up to ¥800 per **period of cover**		Up to ¥4,000 per **period of cover**	
Home nursing	Covered in full up to 30 days per **medical condition**		Covered in full up to 28 weeks per **medical condition**	
Evacuation and transportation				
Emergency transportation	Covered in full			
Evacuation and additional travel expense i) Travel ii) Non-**hospital** accommodation	i) Covered in full ii) Up to ¥1,200 per person per day and ¥40,000 per person per **evacuation**			Up to ¥2,000 per person per day and ¥80,000 per person per **evacuation**
Compassionate **emergency** travel	No **cover**			Offered as standard up to ¥24,000 per **period of cover**
Mortal remains	Up to ¥68,000 per **insured person**			Up to ¥120,000 per **insured person**
Mother and child				
Complications of pregnancy	Covered in full			
New born care	Up to ¥800,000 per **insured person** per **period of cover** and to a maximum of 90 days **hospital** stay			Up to ¥2,000,000 per **insured person** per **period of cover** and to a maximum of 180 days **hospital** stay
New born accommodation	Covered in full			

	Core	Essential	Plus	Elite
Options to reduce costs				
China **private room** restriction	Covered in full			
Outpatient consultation **copay per visit** This **benefit** is available where nil **excess** has been selected.	No **cover**	¥120 (US$15) **copay per visit** or **deductible** *OR* ¥160 (US$20) **copay per visit** or **deductible** *OR* ¥240 (US$30) **copay per visit** or **deductible**		
Inpatient bed limit	6 standard options ranging from: **Inpatient** bed limit ¥600 (US$75) per day, to **inpatient** bed limit ¥4,000 (US$500) per day			
Options to upgrade cover				
Alternative **treatment** without medical referral	No **cover**	Up to ¥8,000 per **insured person** per **period of cover** *OR* Up to ¥16,000 per **insured person** per **period of cover**		
Chronic conditions	No **cover**	No additional options available – see above standard **chronic** conditions **benefit**	Covered in full	
Compassionate **emergency** travel	No **cover**		See above listed benefit – offered as standard up to ¥24,000 per **period of cover**	
Complications of pregnancy – no wait period	Covered in full			
Congenital anomalies - Including pre-existing **congenital anomalies**	Covered in full *OR* Up to ¥800,000 per **medical condition** *OR* Up to ¥2,000,000 per **medical condition**			
Dental 1 - routine dental **treatment**	No **cover**	14 standard options ranging from: Up to ¥2,000 per **period of cover** (with or without 25% **coinsurance**), to up to ¥20,000 per **period of cover** (with or without 25% **coinsurance**)		
Dental 2 - major restorative **treatment**	No **cover**	12 standard options ranging from: Up to ¥4,000 per **period of cover** (with or without 25% **coinsurance**), to up to ¥20,000 per **period of cover** (with or without 25% **coinsurance**)		
Dental 3 - orthodontic dental **treatment**	No **cover**	6 standard options ranging from: Up to ¥4,000 per **period of cover** (with or without 50% **coinsurance**), to up to ¥8,000 per **period of cover** (with or without 50% **coinsurance**)		

	Core	Essential	Plus	Elite
Extended **evacuation** (to the country of choice)	Covered in full			
Out of country transportation for **medically necessary** non-**emergency treatment** as an **inpatient** or **day patient** i) Travel ii) Non-**hospital** accommodation	i) Covered in full ii) Up to ¥1,200 per person per day ¥40,000 per person per **evacuation** *OR* ii) Up to ¥2,000 per person per day ¥80,000 per person per **evacuation**			
Infertility **treatment** (minimum of 10 **employees** required)	No **cover**		Up to ¥200,000 per **member** per lifetime	
Routine pregnancy	No **cover**	8 standard options ranging from: Up to ¥40,000 per pregnancy (with or without 20% **coinsurance**), to covered in full per pregnancy (with or without 20% **coinsurance**)		
Traditional Chinese or Ayurvedic medicine	No **cover**	5 standard options ranging from: ¥250 per session to a maximum of 10 sessions, to up to ¥6,000 per **period of cover** *Two additional options are available for custom **groups**.*		
USA **elective treatment** i) **Inpatient** or **day patient treatment** received inside the **direct settlement network** ii) **Inpatient** or **day patient treatment** received outside the **direct settlement network** iii) **Outpatient 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.	No **cover**	i) Covered in full ii) Up to ¥8,000,000 per **member** per **period of cover** and subject to 50% **coinsurance** iii) Covered in full		
Vision care	No **cover**	One eye exam and a maximum **benefit** of up to ¥2,000 per **period of cover** *OR* One eye exam and a maximum **benefit** of ¥4,000 per **period of cover** *OR* One eye exam and a maximum **benefit** of ¥6,000 per **period of cover**		
Wellness • Routine medical checkups and well-baby checks	5 options ranging from ¥2,000 to ¥12,000 per insured person per period of cover			

	Core	Essential	Plus	Elite
Excess **Policy excess** level options - The **excess** level selected for this **policy** will be applicable to each new **medical condition**.				
¥0	Standard	Optional		
¥400	N/A	Optional		
¥800	N/A	Standard		
¥2,000	N/A	Optional		
¥4,000	N/A	Optional	N/A	
¥8,000	Optional		N/A	
¥16,000	N/A	Optional	N/A	
¥40,000	Optional		N/A	

Moratorium underwriting
Our standard approach to medical underwriting.
At the member level, cover is not provided for any medical condition in existence on the date that individual is accepted into the group (date of entry) until it has been treated such that the individual is symptom and advice-free for two consecutive years following the date of entry with regard to that medical condition. This policy does not cover the treatment of pre-existing chronic conditions.

Full medical underwriting
Plan sponsors may also elect to have members fully underwritten.
Should we accept cover, we may apply additional terms and exclusions, which will be shown on the member's certificate of insurance.

Continuous transfer terms
For members wishing to transfer from other policies. This feature may incur additional premium.
The acceptance by us of the member's original date of entry as shown by the member's current insurer will be applied to the member's policy with us. We will maintain the member's existing underwriting or special acceptance terms, as offered by the member's existing insurer, such as any moratoria or specific exclusions, and the member's 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.

Medical history disregarded
Available to compulsory group schemes of 10 employees or more.
Cover is extended to include treatment for any medical condition or related condition where symptoms have existed or advice has been sought prior to the member's date of entry.

All members must be enrolled within 30 days of eligibility. Any employee or dependant not covered within 30 days of eligibility will be subject to individual medical underwriting.

When MHD is selected for your policy, any waiting periods are removed from benefits that are stated to contain them.

Cover is not extended to include treatment for congenital conditions unless the member has been enrolled within the first year following birth, or unless the optional benefit for congenital anomalies — including pre-existing congenital anomalies' has been purchased.

Plan currency

The Chinese CNY (¥) currency is available to policyholders in China.

Payment frequency

Bank transfers are available on an annual, semi-annual or quarterly basis.

A surcharge will apply for payments made on a quarterly or semi-annual basis.

Communicating with your employees

To assist you in communicating your benefits to your employees and their dependants, we provide the following options:

- Electronic member packs and mailed membership cards
- Printed copies of member packs and membership cards

Membership adjustments

There are three options for plan sponsors to adjust membership when members leave or join the plan:

- **Pay as you go** — Adjustments are credited or debited as adjustments are made.
- **End of year adjustments** — We will reconcile your account at year end.

Policyholder's right of termination

After the commencement date, this policy, or any cover included, may only be terminated by the policyholder, as to all or any class of its members, with effect from the renewal date.

We must be given written notice of intent to non-renew within 15 days of your renewal date. If the policy is terminated by the policyholder at any other time, whatsoever the reason, there will be no return of premium.

Common questions and answers

Q. Are family members eligible for cover as well?

A. 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 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.

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.

Q. Is a medical examination required to enrol in the plan?

A. No. In the rare instance that we require additional information for fair and accurate underwriting purposes, we will ask the applicant to submit a medical report from his/her doctor.

Q. Will the plan cover any illnesses or injuries that members have prior to enrolling in the plan?

A. If you select a moratorium underwriting basis, cover for all pre-existing medical conditions are excluded during the first two years of membership. Future costs will be covered providing members do not have any symptoms, treatment or advice for that condition during this two year period.

You may also apply for Continuous Transfer Terms (CTT).

For groups of 10 or more employees, you may purchase Medical History Disregarded cover.

Q. Does the plan include cover for elective treatment in the U.S.?

A. Cover for elective treatment in the U.S. is only available if the USA Elective Treatment option is selected. This can be purchased with the Essential, Plus and Elite plans.

Where the plan sponsor has not elected to provide USA Elective Treatment, members are covered for accidents and emergencies only. Travelling expenses will be covered under the Evacuation benefit in the event of an emergency, if the visiting location does not offer the appropriate treatment or care needed.

Q. How is the policy excess applied?

A. Members are responsible for paying the policy excess.

Q. How do members know if inpatient treatment is covered?

A. All inpatient treatment is required to be pre-authorised prior to a planned admission into a hospital. Members should contact the Aetna International Member Service Centre to determine whether treatment is covered under the policy.*

Q. How can members submit a claim?

A. Upon inception, each member will receive a membership card. This provides them with the contact information for the Aetna International Member Service Centre and information they need to register for the Aetna International secure member website. Members can use either resource to submit a claim.

Please ensure your claim form is completed in full and returned 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.

*Settlement can be made directly to the hospital. Full details of the claims procedure are available in the member handbook.

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 care, reconstructive surgery and rehabilitation

Charges incurred for the treatment of a medical condition, including stabilisation of an acute exacerbation of a 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) Nursing by a qualified nurse.

iv) Surgical procedure fees and operating theatre fees.

v) Medical practitioner fees including surgeon, consultations, specialist and anaesthetist fees.

vi) Diagnostic procedures including but not limited to pathology tests, Ultrasound scans and X-rays.

vii) Drugs, dressings, medicines and appliances prescribed by a medical practitioner or specialist, including Traditional Chinese Medicine.

viii) 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.

ix) Rehabilitation (including outpatient treatment) in a recognised rehabilitation unit of a hospital subsequent to inpatient treatment lasting 3 days or more. The rehabilitation must take place within 14 days of discharge from the inpatient admission and must be recommended and under the direct control of a Medical Practitioner. 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 with us.

Durable medical equipment, prosthetic and orthotic supplies (DMEPOS): The following benefits are covered:

i) Medically necessary durable medical equipment prescribed by a treating Medical Practitioner, which is necessary to deliver or facilitate the delivery of prescribed drugs and dressings. This excludes hearing aids unless the hearing benefit has been purchased.
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 medical practitioner. 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 must be 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.

Necessary burial or cremation fees including:

- The cost of reopening a grave and burial costs, or
- The cost of opening a new grave and burial costs, including any exclusive right of burial fee, or
- In the case of cremation
  1. The cremation fee
  2. The cost of any doctor's certificates
  3. The cost of removing a pacemaker or other medical device which must be removed before the cremation

But not including costs related to other funeral expenses, such as:

- Funeral director's fees
- Flowers
- The cost of any documents needed for the release of the money, savings and property of the deceased
- The necessary cost of a return journey for you to either
  1. Arrange the funeral, or
  2. Attend the funeral

Mother and child benefits

Complications of pregnancy: Treatment of a defined medical condition arising during the antenatal stages of pregnancy or during childbirth. The conditions covered are ectopic pregnancy, gestational diabetes, hydatidiform mole, miscarriage (actual or threatened), pre-eclampsia, failure to progress in labour or stillbirth. Post-partum hemorrhage and retained placental membrane that occur during childbirth are also covered by this benefit. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births are excluded from this benefit. Post natal checkups needed as a result of one the above complications of pregnancy are covered for a period of 6 weeks. 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.

The new born baby must be added to the policy to avail of this benefit. 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, following discharge from the original delivery.

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.

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.

Complications of pregnancy — No wait period: Treatment of a defined medical condition arising during the antenatal pregnancy or during childbirth. The conditions covered are ectopic pregnancy, gestational diabetes, hydatidiform mole, miscarriage (actual or threatened), pre-eclampsia, failure to progress in labour or stillbirth. Post-partum hemorrhage and retained placental membrane that occur during childbirth are also covered by this benefit. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births are excluded from this benefit. Post natal checkups needed as a result of one the above complications of pregnancy are covered for a period of 6 weeks.

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 unerrupted 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 ofthis 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 unerrupted 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 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 unerrupted 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.

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 unerrupted 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 to us 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 three 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 non-medical previous caesarean sections.

This benefit also covers the cost of pre-natal checkups, and post-natal checkups for up to six weeks after delivery, 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 only the following for a new born child:

- One physical examination;
- Vitamin K, hepatitis B and BCG vaccinations;
- Circumcision;
- Routine blood tests for PKU, congenital hypothryriodism and G6PD;
- One hearing examination; and
- Reasonable accommodation costs for no more than four nights, if the mother is admitted and not suffering any complications.

The policy excess does not apply to this benefit. A 12 month wait period applies from the purchase date of this benefit or the member's date of entry, whichever is the later.

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

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

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

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.

Complaints procedures

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.

Who to contact with a complaint

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

Our complaints handling procedures

Complaints will:

- Be acknowledged promptly
- Be investigated competently, efficiently and impartially
- 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.

There for your employees.
Here for you.

Learn more about how our solutions can work for you.

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