

# Maternity 75, 150 & 200

## 2021 Benefits Schedule

### USD

For plans starting on or after  
1 January 2021



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# At a glance



## Overall plan limit

Up to 1,700,000 USD



## Benefits

### Pregnancy and childbirth

Maternity 75: Up to 7,500 USD

Maternity 150: Up to 15,000 USD

Maternity 200: Up to 40,000 USD

### Medical evacuation

Paid in full

### Local ambulance

Paid in full

### Emergency treatment outside your area of cover

Maternity 75: Up to 7,500 USD

Maternity 150: Up to 15,000 USD

Maternity 200: Worldwide



## Which benefit can you choose?

Your plan	Maternity 75	Maternity 150	Maternity 200
Pioneer 1750	✗	✗	✗
Pioneer 2500	✓	✗	✗
Pioneer 4000	✓	✓	✗
Pioneer 5000	✓	✓	✓
Pioneer 5000+	✗	✗	✓

If Area 1 is your area of cover on your Pioneer 5000 or 5000+ plan, you are only eligible for Maternity 200.

# Good to know

## Eligibility

This plan is only available to female members. You can only join this plan between the ages of 18 and 44 inclusive. Once you have reached the age of 46 during your plan year, your Maternity plan will not be renewed.

## Before you're treated

It's important you get our approval (also known as preauthorisation) before you're treated for the following treatments and services:

- Medical evacuation
- Inpatient or daycare treatment admission
- A single treatment or service that costs more than 500 USD or equivalent

If you're unable to ask for approval because it's an emergency, you or someone on your behalf must let us know about the emergency within 24 hours. You'll find more information about claiming in your Handbook.

## Your deductibles

### Coinsurance

The maternity coinsurance you choose when you first join the plan as shown on your Certificate of Insurance will apply for the first 24 months continuous cover under the plan after which time you have the option to change your coinsurance at renewal.

# What's covered

## 1 Overall plan limit

We'll pay reasonable costs up to the overall **plan** limit in each **plan year**. **Benefit** limits shown as 'Paid in full' are subject to the overall **plan** limit.

All **benefit** limits in this document apply to each pregnancy. If your pregnancy spans more than one **plan year**, any **benefit** we paid under your Maternity **plan** for **treatment** or services received by **you** in the **plan year** when the pregnancy began will be taken from the **benefit** limit in the following **plan year**.

Maternity  
**75**

Maternity  
**150**

Maternity  
**200**

**1,700,000 USD**

**1,700,000 USD**

**1,700,000 USD**

## 2 Pregnancy and Childbirth

For natural and assisted conception pregnancies

- 12 routine antenatal checkups and three routine 2D ultrasound scans, or one antenatal package, during each uncomplicated pregnancy
- Antenatal vitamins
- Delivery costs, nursing fees and **hospital** accommodation costs for uncomplicated childbirth
- Postnatal checkups
- **Hospital** accommodation costs for the newborn to stay with **you** for up to four nights immediately after childbirth

We'll also pay the following routine costs for the newborn for the first 30 days after his or her birth, even if **you** do not add the newborn to your Pioneer **plan**:

- One physical examination
- Vitamin K, hepatitis B and BCG vaccinations
- Screening tests for PKU, congenital hypothyroidism and G6PD
- One hearing examination

This **benefit** also extends to the cost of elective circumcision for newborn males. Cover is available for up to 30 days from birth, and paid up to 500 USD within the **benefit** limit shown.

✓  
Paid up to  
7,500 USD

✓  
Paid up to  
15,000 USD

✓  
Paid up to  
20,000 USD

## 2 Pregnancy and Childbirth Continued

For natural and assisted conception pregnancies

**Treatment** for medical maternity complications during pregnancy or childbirth, if the pregnancy is the result of assisted conception.

We'll also pay the following routine costs for the newborn for the first 30 days after his or her birth, even if you do not add the newborn to your Pioneer plan:

- Hospital accommodation costs for the newborn to stay with you immediately after a complicated childbirth.
- One physical examination
- Vitamin K, hepatitis B and BCG vaccinations
- Screening tests for PKU, congenital hypothyroidism and G6PD
- One hearing examination

This benefit also extends to the cost of elective circumcision for newborn males. Cover is available for up to 30 days from birth, and paid up to 500 USD within the benefit limit shown.

**i** Your coinsurance applies, as shown on your Certificate of Insurance.

**i** These benefits are only available after you have had 12 months' continuous cover from the date that the benefit was first introduced on your plan.

**Treatment** for medical maternity complications during pregnancy or childbirth, if the pregnancy is the result of natural conception.

We'll also pay the following routine costs for the newborn for the first 30 days after his or her birth, even if you do not add the newborn to your Pioneer plan:

- Hospital accommodation costs for the newborn to stay with you immediately after a complicated childbirth.
- One physical examination
- Vitamin K, hepatitis B and BCG vaccinations
- Screening tests for PKU, congenital hypothyroidism and G6PD
- One hearing examination

This benefit also extends to the cost of elective circumcision for newborn males. Cover is available for up to 30 days from birth, and paid up to 500 USD within the benefit limit shown.

### Maternity 75

✓  
Paid up to  
7,500 USD

10%  
Or your chosen option:  
0%  
20%  
30%

✓  
Paid up to  
15,000 USD

### Maternity 150

✓  
Paid up to  
15,000 USD

10%  
Or your chosen option:  
0%  
20%  
30%

✓  
Paid up to  
50,000 USD

### Maternity 200

✓  
Paid up to  
40,000 USD

10%  
Or your chosen option:  
0%  
20%  
30%

✓  
Paid in full

### 3 Medical evacuation

The costs to transport **you** to the nearest appropriate medical facility for **treatment** of a medical maternity complication when **we** agree that your **medical condition** is an **emergency** following an assessment by a **medical practitioner** in a local medical facility, and that **treatment** is not available locally in any public or private medical facility.

This **benefit** extends to the costs for **emergency treatment** **you** receive during the journey.

If **we** have arranged for **you** to be transported outside your **area of cover**, **we'll** pay any related costs **you** incur in the country **you're** evacuated to under the sections of your **Benefits Schedule** that would normally apply when **you're** within your **area of cover**.

Economy class travel costs for **you** to go back to your choice of your **country of residence**, or your **home country**, after your **emergency** evacuation that was covered under this **plan**.

If **we** agree that **you're** not medically fit to travel following your **treatment**, this **benefit** extends to reasonable overnight accommodation costs including breakfast until **you're** fit to travel.

Costs of:

- one companion to accompany **you**, or travel at the same time if they're not able to accompany **you** during your **emergency** evacuation, if your **medical condition** is **critical** or **you're** expected to stay in **hospital** for seven or more nights; or
- one companion or non-medical escort needed to assist **you** during your **emergency** evacuation if your **medical condition** prevents **you** from travelling alone, **you** do not need a medical escort, your **medical condition** is not **critical** and **you're** not expected to stay in **hospital** for seven or more nights.

**We'll** cover costs for:

- One return economy class journey, including taxi transfers to and from their hotel on arrival and departure
- A taxi from their hotel to the **hospital**, and back, once a day for the duration of your evacuation
- Their reasonable overnight accommodation costs including breakfast for the duration of your evacuation, until **you're** fit to travel back to your **country of residence** or **home country**.

The costs to transport **you** to appropriate medical facilities for **treatment** related to your pregnancy if it's not an **emergency**.

**We'll** cover costs for return economy class travel to a location of your choice within your **area of cover** if:

- **we** agree appropriate **treatment** is not available locally in any public or private medical facility, and
- **we** agree appropriate **treatment** is available in your chosen location.

**We'll** also cover costs for airport taxi transfers.

**You're** limited to three return journeys for each pregnancy.

Maternity  
75

Maternity  
150

Maternity  
200

✓  
Paid in full

✓  
Paid in full

✓  
Paid in full

Not covered

✓  
Paid in full

✓  
Paid in full

#### 4 Local ambulance

Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local hospital in a pregnancy or childbirth **emergency**.

Maternity  
**75**

✓  
Paid in full

Maternity  
**150**

✓  
Paid in full

Maternity  
**200**

✓  
Paid in full

#### 5 Emergency treatment outside area of cover

Inpatient and daycare treatment for any **emergency** medical maternity complications during pregnancy or childbirth outside your **area of cover**.

✓  
Paid up to  
7,500 USD

✓  
Paid up to  
15,000 USD

Not  
Applicable

Outpatient treatment for any **emergency** medical maternity complications during pregnancy outside your **area of cover**.

✓  
Paid up to  
250 USD

✓  
Paid up to  
500 USD

Area of cover  
is worldwide

Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local hospital for an **emergency** medical maternity complication when **you** are outside your **area of cover**.

✓  
Paid up to  
500 USD

✓  
Paid up to  
500 USD

**i** You're only covered under this **benefit** if the **emergency** would normally be covered when you're within your **area of cover** and you've completed any waiting periods shown in this **Benefits Schedule**.

**i** If you are 26 weeks or more into your pregnancy, this **benefit** is only available if you have been outside your **area of cover** for no more than 14 days at your date of admission for **emergency inpatient or daycare treatment** or the date you receive **emergency outpatient treatment**. You must not travel against the advice of a **medical practitioner, specialist or nurse** at any time during your pregnancy.

## Exclusions and other terms

This plan doesn't cover 3D or 4D Ultrasound scans

The Maternity 75, 150 and 200 plans are also subject to the general exclusions set out in your Handbook (The details) and the other terms and conditions of your plan.

All cover provided under this Benefits Schedule is subject to the terms of your plan documents.

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