Pioneer 1750–5000

Benefits Schedule

2019
USD

For plans starting on or after 1 July 2019

M017-4E-010719

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At a glance

Overall plan limit

Pioneer 1750 Up to 1,750,000 USD

Pioneer 2500 Up to 2,500,000 USD

Pioneer 4000 Up to 4,000,000 USD

Pioneer 5000 Up to 5,000,000 USD

Annual excess

This is the total **excess** each **member** needs to pay towards **claims** in the **plan year**.

Pioneer 1750
Nil, 1,000 USD, 2,000 USD, 4,000 USD or 8,000 USD, as shown on your **Certificate of Insurance**.

Pioneer 2500, 4000 and 5000
No annual **excess**

Outpatient coinsurance

This is the percentage of **coinsurance** each **member** needs to pay towards **claims** in the **plan year**.

Pioneer 1750
No **outpatient coinsurance**.

Pioneer 2500, 4000 and 5000
0%, 10% up to a maximum 2,000 USD, 20% up to a maximum 4,000 USD or 30% up to a maximum 5,000 USD, as shown on your **Certificate of Insurance**.

Good to know

Using this Benefits Schedule

Some words and phrases have specific meanings, **we**'ve highlighted them in bold print and **you**'ll find their definitions in your Handbook.

Before you're treated

It's important **you** request **our** approval before **you** receive **treatment** for the following **treatments** and services:

- Medical evacuation
- **Inpatient** or **daycare treatment** admission
- Psychiatric **treatment**
- Prescription for more than three months' supply of drugs for a **chronic medical condition**
- 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.

Your deductibles

Annual excess

An annual **excess** applies to Pioneer 1750. This is the total **excess** each **member** needs to pay towards **claims** in the **plan year** and applies to all **benefits**, except where explicitly stated in sections: 6 Cancer Care, 19 Dental treatment, 20 Wellness and 22 Hospital cash. Your chosen annual **excess** is shown on your **Certificate of Insurance**.

Outpatient coinsurance

We'll apply your chosen level of **outpatient coinsurance**, as shown on your **Certificate of Insurance**, to **outpatient claims**. Once the total amount of **outpatient coinsurance you** have paid in a **plan year** reaches the maximum amount, **you** won't have to pay any more **outpatient coinsurance.**

Dental coinsurance

We'll apply **our dental coinsurances** to **dental claims** under the **dental benefits** only. See 19 Dental treatment.

What's covered

The **benefits** noted below are subject to the terms, conditions and exclusions contained in your **plan documents**. **We**'ll only pay reasonable costs for **claims** for **treatment** and services that are **benefits** and are **medically necessary**. Reasonable costs are the average cost of **treatment**, expertise or services given by similar types of medical provider within the same country or geographical region, based on **our** knowledge, experience and reasonable opinion.

1 Overall plan limits	Pioneer **1750**	Pioneer **2500**	Pioneer **4000**	Pioneer **5000**
We'll pay reasonable costs for **benefits** up to the overall **plan** limit for each **member** in each **plan year**. **Benefit** limits shown as 'Paid in full' are subject to the overall **plan** limit for each **member** in each **plan year**.	**1,750,000 USD**	**2,500,000 USD**	**4,000,000 USD**	**5,000,000 USD**

2 Inpatient and daycare treatment				
Medical costs including intensive care, theatre, **hospital** accommodation, **medical practitioners**, **specialists**, anaesthetists, nursing, **appliances** and prescribed drugs and dressings.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
Kidney dialysis.				
MRI, PET and CT scans, X-rays, pathology and other **diagnostic tests and procedures.**				
Reconstructive surgery to restore natural function or appearance within 12 months of an **accident** or surgery.				
Speech and language therapy and occupational therapy as part of your **inpatient treatment**.				
Medical services of a **nurse** that would have been part of your **inpatient** or **daycare treatment** when these are received in your home instead of in **hospital**.				
All **inpatient treatment** needed for **acute medical conditions** that begin before the **member** is eight days old, if the **member** was conceived by natural conception. Where **we** agree that parent accommodation is needed in relation to this **benefit** and would normally be paid under section 3 Parent accommodation, it will be paid under this section instead.	✓ Up to a **lifetime limit** of 150,000 USD	✓ Up to a **lifetime limit** of 150,000 USD	✓ Up to a **lifetime limit** of 150,000 USD	✓ Up to a **lifetime limit** of 150,000 USD

3 Parent accommodation	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Hospital accommodation costs for a parent or legal guardian to stay with the **member** if they're aged 17 or under and receiving **inpatient treatment** that **we** cover under 2 Inpatient and daycare treatment.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full

4 Outpatient post-hospitalisation treatment	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Outpatient treatment for 90 days after **you**'re discharged following **inpatient** or **daycare treatment** for the same **acute medical condition**. This **benefit** covers **medical practitioners'** and **specialists'** fees, surgical procedures, prescribed drugs and dressings, MRI, PET and CT scans, X-rays, pathology and other **diagnostic tests and procedures.**	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

5 Rehabilitation

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
This **benefit** is only available if: • **you**'ve received **inpatient treatment** for three or more consecutive days for the same **medical condition** • **you**'ve stayed in **hospital** for three or more consecutive nights for the same **medical condition**, • your **inpatient treatment** was covered under 2 Inpatient and daycare treatment, • a **medical practitioner** or **specialist** has referred **you** for rehabilitation, and • your rehabilitation starts: – after **you**'re discharged from **hospital** following your **inpatient treatment**, or – when **you**'re transferred to a rehabilitation unit following your **inpatient treatment**. Your first session must be no more than 14 days after **you**'re discharged or transferred. This **benefit** covers **inpatient**, **daycare** and **outpatient** physiotherapy, speech and language therapy and occupational therapy. **We**'ll also pay for accommodation costs at the rehabilitation unit when **medically necessary**. *This section applies before any available **benefit** limit shown in 8 Physiotherapy and complementary medicine.*	✔ Paid in full for up to 30 days after **you**'re discharged or transferred	✔ Paid in full for up to 60 days after **you**'re discharged or transferred	✔ Paid in full for up to 90 days after **you**'re discharged or transferred	✔ Paid in full for up to 120 days after **you**'re discharged or transferred
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

6 Cancer care

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
All **treatment** for, or related to, a diagnosed cancer. This includes **palliative treatment** and care.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
*Annual **excess***	Not applicable	Not applicable	Not applicable	Not applicable

7 Outpatient treatment

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Surgical procedures.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
Outpatient pre-operative tests up to 72 hours before **inpatient** or **daycare treatment** covered under 2 Inpatient and daycare treatment.	✓ Paid up to 1,000 USD	✓ Paid up to 5,000 USD	✓ Paid up to 15,000 USD	✓ Paid in full
Medical practitioners' and **specialists'** fees, prescribed drugs and dressings, MRI scans, X-rays, pathology and **diagnostic tests and procedures**.	Not covered			✓ Paid in full
Kidney dialysis.	Not covered			✓ Paid in full
PET and CT scans.	Not covered	✓ Paid in full	✓ Paid in full	✓ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

8 Physiotherapy and complementary medicine

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Physiotherapy as part of **inpatient** or **daycare treatment**. *Outpatient coinsurance doesn't apply*	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Post-hospitalisation **outpatient** physiotherapy. This **benefit** is available for 90 days after each **inpatient** or **daycare** admission.	✔ Paid up to 750 USD	✔ Paid up to 1,500 USD	✔ Paid up to 2,000 USD	✔ Paid in full
Outpatient physiotherapy when a **medical practitioner** or **specialist** refers **you**. *We reserve the right to seek further information from your **medical practitioner** or therapist if **you** received further **treatment** after **you**'ve completed six sessions.*	Not covered			✔ Paid in full
Outpatient podiatry, osteopathic and chiropractic **treatment**, when a **medical practitioner** or **specialist** refers **you**.	Not covered			✔ Paid up to 4,000 USD
Outpatient traditional Chinese medicine, ayurvedic medicine, acupuncture and homeopathic **treatment**.	Not covered	✔ Paid up to 300 USD	✔ Paid up to 750 USD	✔ Paid up to 1,500 USD
*We reserve the right to seek further information from your therapist if **you** received further **treatment** after **you**'ve completed four sessions for any one **medical condition**.*				
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

9 Psychiatric treatment

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Up to 30 days **inpatient** psychiatric **treatment** and psychotherapy in the **plan year**. *Outpatient coinsurance doesn't apply*	Not covered	✓ Paid up to 5,000 USD	✓ Paid up to 10,000 USD	✓ Paid in full
Outpatient psychiatric **treatment** and psychotherapy.	Not covered	✓ Paid up to 1,000 USD	✓ Paid up to 2,000 USD	✓ Paid up to 10,000 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

10 Durable medical equipment
including prosthetic and orthotic supplies

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
We'll cover costs for: • Items a **medical practitioner** or **specialist** prescribes which are needed to deliver prescribed drugs and apply dressings • Buying and fitting of devices or items **medically necessary** for **treatment** including spinal supports, orthopaedic braces and air cast boots • The rental or initial purchase of crutches or a wheelchair if **medically necessary** • The initial buying and fitting of external prostheses needed after surgery, including artificial eyes and limbs • The buying and fitting of **medically necessary** orthotic supplies, including insoles and orthotic supports *If the costs are related to a **medical condition we** cover under the following sections, **we**'ll cover these within the **benefit** limits of that section:* 6 *Cancer care* 11 *Congenital abnormalities* 12 *HIV or AIDS* 13 *Organ transplants* 14 *Terminal care* 23 *Emergency treatment outside your area of cover*	✓ Paid up to 1,000 USD	✓ Paid up to 1,000 USD	✓ Paid up to 1,000 USD	✓ Paid up to 2,000 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

11 Congenital abnormalities

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
All **treatment** for diagnosed **congenital abnormalities** and any **related medical conditions**. This includes **palliative treatment** and care for a **congenital abnormality** or any **related medical condition**. *We'll cover costs for an organ transplant for **congenital abnormalities** and any **related medical conditions** under section 13 Organ transplants.*	Not covered	✓ Up to a **lifetime limit** of 25,000 USD	✓ Up to a **lifetime limit** of 50,000 USD	✓ Up to a **lifetime limit** of 100,000 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

12 HIV or AIDS

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
All **treatment**, including **palliative treatment** and care, for diagnosed HIV or AIDS and all **related medical conditions**.	Not covered	✓ Paid up to 5,000 USD	✓ Paid up to 10,000 USD	✓ Paid up to 15,000 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

13 Organ transplants

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Kidney, pancreas, liver, heart or lung transplants and any related **treatment**.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

14 Terminal care

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Palliative treatment and care for a **medical condition** which is diagnosed as **terminal**. *If the costs are related to a **medical condition we** cover under the following sections, **we**'ll cover these within the **benefit** limits of that section:* 6 *Cancer care* 11 *Congenital abnormalities* 12 *HIV or AIDS*	Not covered	✔ Paid in full	✔ Paid in full	✔ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

15 Medical evacuation

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
The costs to transport **you** to the nearest appropriate medical facility when your **medical condition** is an **emergency** and **we** agree appropriate **treatment** is not available locally. This **benefit** extends to the costs for **emergency treatment you** receive during the journey. If **we** have transported **you** 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**.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Economy class travel costs for **you** to go back to your choice of your **country of residence**, or your **home country**, after your **emergency** medical evacuation that was covered under this **plan**.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full

15 Medical evacuation
Continued

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Costs of one **dependant** or companion having to accompany **you** or to travel at the same time if they are not able to accompany **you** during the actual **emergency** medical evacuation. This **benefit** will only become available if your **medical condition** is **critical** or **you**'re expected to stay in **hospital** for seven or more nights. For the duration of your evacuation and period of admission **we**'ll cover: • Costs for return economy class travel, including taxi transfers to and from the hotel on arrival and departure • A taxi from the hotel to the **hospital**, and back, once a day • Reasonable overnight accommodation costs including breakfast	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
The costs to transport **you** to appropriate medical facilities to receive **treatment** when your **medical condition** is 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, and • **we** agree appropriate **treatment** is available in your chosen location. **We**'ll also cover costs for airport taxi transfers. Cover is only available under this **benefit** if the **treatment** is covered under 2 Inpatient or daycare treatment, or 4 Outpatient post-hospitalisation treatment to 14 Terminal care.	**Optional benefit** Only applicable if selected ✔ Paid up to 2,000 USD	**Optional benefit** Only applicable if selected ✔ Paid up to 2,000 USD	**Optional benefit** Only applicable if selected ✔ Paid up to 2,000 USD	**Optional benefit** Only applicable if selected ✔ Paid up to 2,000 USD

16 Local ambulance

Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000

Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local **hospital** because of an **emergency** or due if **treatment** is **medically necessary**.

*Cover is only available under this **benefit** if the **treatment** is covered under the following sections:*

- 2 *Inpatient and daycare treatment*
- 4 *Outpatient post-hospitalisation treatment*
- 6 *Cancer care*
- 7 *Outpatient treatment*
- 9 *Psychiatric treatment*
- 11 *Congenital abnormalities*
- 12 *HIV or AIDS*
- 13 *Organ transplants*
- 14 *Terminal care*

Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full

17 Mortal remains

Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000

If **you** die outside your **home country**, **we**'ll cover reasonable costs:

- to transport your body or mortal remains to your **home country** or your **country of residence** as directed by your next of kin or estate; or
- for your burial or cremation at the place of your death as directed by your next of kin or estate.

In the event of your burial, **we**'ll cover:

- the cost of opening or reopening a grave;
- any exclusive right of burial fee; and
- burial costs.

In the event of your cremation, **we**'ll cover:

- the cost of any doctor's certificates; and
- cremation costs, including the removal of any medical device before the cremation

This **benefit** does not extend to the purchase of a burial plot, or funeral costs, including, but not limited to, flowers and the funeral director's fees.

If **you** die within your **home country**, **we**'ll cover reasonable costs to transport your body to the place of your burial or cremation as directed by your next of kin or estate. This **benefit** does not extend to any costs related to your burial or cremation.

Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full

18 Compassionate emergency visit

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Costs **you** have to pay for one economy class return travel ticket from your **area of cover** for **you** to: • visit a **close family member** if their **medical condition** is **critical**, or • attend their burial or cremation following their death. **We**'ll cover a maximum of one return journey in the **plan year**.	Not covered	Not covered	✓ Paid in full	✓ Paid in full

19 Dental treatment

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Outpatient dental treatment for damage to **natural teeth** caused by an **accident** when: • the **treatment** can only be provided after **you**'ve received **inpatient treatment** related to the **accident**, and • **you** receive **treatment** within 90 days after **you**'re discharged from **hospital** for your related **inpatient treatment**. This **benefit** includes the cost to supply and fit **dental** implants.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
Outpatient dental treatment for damage to **natural teeth** caused by an **accident**, except when the damage is caused by eating. Cover is only available when **you** receive **treatment** for the accidental damage within 10 days of the **accident**. This **benefit** also includes one follow-up consultation within 30 days of the **accident**.	Not covered	✓ Paid up to 500 USD	✓ Paid up to 750 USD	✓ Paid up to 1,500 USD
*Your chosen annual excess applies, as shown on your **Certificate of Insurance**.*	Nil or 1,000 USD or 2,000 USD or 4,000 USD or 8,000 USD	Not applicable	Not applicable	Not applicable
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD
Dental coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

19 Dental treatment
Continued

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Routine **outpatient dental treatment**, including **treatment** for accidental damage to **natural teeth** when the damage is caused by eating. This **benefit** covers **dental** examinations, scraping, cleaning and polishing, X-rays, composite fillings and simple non-surgical extractions only. Cover is available after **you**'ve had 182 days' continuous cover from the date that the **benefit** was first included in your **plan**.	Not covered	Not covered	**Optional benefit** Only applicable if selected	**Optional benefit** Only applicable if selected
Major restorative **dental treatment**, including **treatment** for accidental damage to **natural teeth** when the damage is caused by eating. This **benefit** covers: • Surgical extractions, including wisdom teeth • Root canal **treatment** • The cost to supply, fit and repair crowns, bridges and dentures • X-rays needed to support major restorative **dental treatment** • Gum **treatment** Cover is available after **you**'ve had 182 days' continuous cover from the date that the **benefit** was first included in your **plan**.	Not covered	Not covered	✓ Paid up to 750 USD in each plan year	✓ Paid up to 1,500 USD in each plan year
Dental coinsurance	Not applicable	Not applicable	25%	25%
Annual ***excess***	Not applicable	Not applicable	Not applicable	Not applicable
Outpatient coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

20 Wellness

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Members aged 18 or over: **routine health checks** including cancer screening, cardiovascular examinations, neurological examinations, vital sign tests and vaccinations.	Not covered	Not covered	✓ Paid up to 500 USD	✓ Paid up to 1,000 USD
Members aged 17 or under: **routine health checks** and vaccinations.	Not covered	Not covered		
One sight examination and one hearing examination in the **plan year**.	Not covered	Not covered	Not covered	✓ Paid up to 250 USD
Annual excess	Not applicable	Not applicable	Not applicable	Not applicable

21 Hormone replacement therapy

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Hormone replacement therapy for symptoms of the menopause.	Not covered	Not covered	✓ Paid up to 500 USD	✓ Paid up to 500 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

22 Hospital cash

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
We'll pay **you** for each night **you** stay in a **hospital** for **inpatient treatment**: • if the **inpatient treatment** and **hospital** accommodation **you** receive during your stay are provided free of charge, and • **we** would otherwise cover the **treatment** or services **you** receive during your stay under this **plan**. **We**'ll pay for a maximum of 20 nights in the **plan year**.	✓ 125 USD paid to **you** for each night	✓ 125 USD paid to **you** for each night	✓ 125 USD paid to **you** for each night	✓ 125 USD paid to **you** for each night
Annual excess	Not applicable	Not applicable	Not applicable	Not applicable

23 Emergency treatment outside your area of cover

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Inpatient and daycare treatment when your medical condition is an emergency. *Outpatient coinsurance doesn't apply*	✓ Paid up to 5,000 USD	✓ Paid up to 15,000 USD	✓ Paid up to 30,000 USD	✓ Paid up to 50,000 USD
Outpatient treatment when your medical condition is an emergency.	Not covered	✓ Paid up to 500 USD	✓ Paid up to 500 USD	✓ Paid up to 500 USD
Your chosen outpatient coinsurance applies, as shown on your Certificate of Insurance.	Not applicable	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD
Costs of the appropriate type of ambulance needed to transport you to the nearest appropriate local hospital. This benefit is only available when your medical condition is an emergency. *We will only cover you if the emergency would be covered if you were within your area of cover*	✓ Paid up to 500 USD	✓ Paid up to 500 USD	✓ Paid up to 500 USD	✓ Paid up to 500 USD

24 Health management services

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
Access to our CARE team to receive tailored information and discuss any chronic condition and disease management	Not included	✓ Included	✓ Included	✓ Included

25 red24 security services

	Pioneer 1750	Pioneer 2500	Pioneer 4000	Pioneer 5000
AdviceLine: 24/7 personal security information and advice for all your travel safety queries. Visit www.red24.com/aetna to register for this service.	✓ Included	✓ Included	✓ Included	✓ Included
ActionResponse: 24/7 international rescue and response service for you in a potentially life-threatening, non-medical event. Visit www.red24.com/aetna to register for this service.	Not included	Not included		

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

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Notice to United Kingdom residents: In the UK, Aetna Insurance Company Limited (FRN 458505) has issued and approved this communication.

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