Pioneer 5000+

Benefits Schedule

2019
USD

For plans starting on or after 1 July 2019

Visit **alaininsurance.com**
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M016-144E-010719

At a glance

Overall plan limit

Pioneer 5000+
Up to 5,000,000 USD

Outpatient coinsurance

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

Pioneer 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

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 limit

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**.	**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
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.	
All **inpatient treatment** needed for **acute medical conditions** that begin before the **member** is eight days old, if the **member** was conceived by assisted 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

3 Parent accommodation

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

4 Outpatient post-hospitalisation treatment

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
*i Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	0% or 10% to max 2,000 USD or 20% to max 4,000 USD or 30% to max 5,000 USD

5 Rehabilitation

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 120 days after **you**'re discharged or transferred
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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

All **treatment** for, or related to, a diagnosed cancer. This includes **palliative treatment** and care.	✔ Paid in full

7 Outpatient treatment

Surgical procedures.	✔ Paid in full
Outpatient pre-operative tests up to 72 hours before **inpatient** or **daycare treatment** covered under 2 Inpatient and daycare treatment.	✔ Paid in full
Medical practitioners' and **specialists'** fees, prescribed drugs and dressings, MRI scans, X-rays, pathology and **diagnostic tests and procedures**.	✔ Paid in full
Kidney dialysis.	✔ Paid in full
PET and CT scans.	✔ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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

Physiotherapy as part of **inpatient** or **daycare treatment**. *i* ***Outpatient coinsurance*** *doesn't apply*	✔ Paid in full
Post-hospitalisation **outpatient** physiotherapy. This **benefit** is available for 90 days after each **inpatient** or **daycare** admission.	✔ Paid in full
Outpatient physiotherapy when a **medical practitioner** or **specialist** refers **you**. *i* ***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.*	✔ Paid in full
Outpatient podiatry, osteopathic and chiropractic **treatment**, when a **medical practitioner** or **specialist** refers **you**.	✔ Paid up to 4,000 USD
Outpatient traditional Chinese medicine, ayurvedic medicine, acupuncture and homeopathic **treatment**.	✔ Paid up to 1,500 USD
i ***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****.*	
i Your chosen ***outpatient coinsurance*** *applies, as shown on your* ***Certificate of Insurance****.*	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

Up to 30 days **inpatient** psychiatric **treatment** and psychotherapy in the **plan year**. *i* ***Outpatient coinsurance*** *doesn't apply*	✔ Paid in full
Outpatient psychiatric **treatment** and psychotherapy.	✔ Paid up to 10,000 USD
i Your chosen ***outpatient coinsurance*** *applies, as shown on your* ***Certificate of Insurance****.*	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

We'll cover costs for: • Items a **medical practitioner** or **specialist** prescribes which are needed to deliver prescribed drugs and 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 2,000 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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

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**.	Up to a **lifetime** limit of 100,000 USD
All **treatment** for diagnosed **congenital abnormalities** and any **related medical conditions** that are diagnosed before an insured **member** is 31 days old: • if the pregnancy is the result of natural conception, • if they are added to the plan before they are 31 days old, and • the **treatment** would normally be covered under the **lifetime limit** above. Once the **member** reaches five years of age, cover will only be available under the **lifetime limit** above. Any costs paid under this section will not be deducted from the **lifetime limit** shown above. If the pregnancy is the result of assisted conception, cover will only be available under the **lifetime limit** above.	Paid in full
***We**'ll cover costs for an organ transplant for **congenital abnormalities** and any **related medical conditions** under section 13 Organ transplants.*	
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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

All **treatment**, including **palliative treatment** and care, for diagnosed HIV or AIDS and all **related medical conditions**.	✓ Paid up to 15,000 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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

Kidney, pancreas, liver, heart or lung transplants and any related **treatment**.	✓ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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

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*	✓ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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

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
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

15 Medical evacuation Continued

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
The costs to transport **you** to appropriate medical facilities to receive **treatment** when your **medical condition** is not an **emergency**.	**Optional benefit** Only applicable if selected
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.	✔ Paid up to 2,000 USD

16 Local ambulance

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

17 Mortal remains

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.	✔ Paid in full

18 Compassionate emergency visit

Benefit	
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**.	Paid in full

19 Dental treatment

Benefit	
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
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**.	Paid up to 1,500 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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
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 this optional **benefit** was first introduced on your **plan**.	**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 this optional **benefit** was first included in your **plan**.	Paid up to 1,500 USD
Dental coinsurance	25%

20 Wellness

Benefit	
Members aged 18 or over: **routine health checks** including cancer screening, cardiovascular examinations, neurological examinations, vital sign tests and vaccinations.	Paid up to 1,000 USD
Members aged 17 or under: **routine health checks** and vaccinations.	
One sight examination and one hearing examination in the **plan year**.	Paid up to 250 USD

21 Hormone replacement therapy

Hormone replacement therapy for symptoms of the menopause.	Paid up to 500 USD
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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

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

23 Emergency treatment outside your area of cover

Inpatient and **daycare treatment** when your **medical condition** is an **emergency**. *Outpatient coinsurance doesn't apply* **Outpatient treatment** when your **medical condition** is an **emergency**.	Not applicable **Area of cover** is worldwide
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	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***	Not applicable **Area of cover** is worldwide

24 Health management services

Access to **our** CARE team to receive tailored information and discuss any chronic condition and disease management.	Included

25 red24 security services

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
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.	

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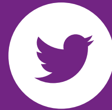

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