Pioneer Dubai 50

Benefits Schedule

2019
USD

For plans starting on or after 1 July 2019

Administered by:

Insured by:

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M015-176E-010719

At a glance

Overall plan limit

Pioneer Dubai 50
Up to 50,000 USD

Overall DHA limit

Pioneer Dubai 50
Up to 41,000 USD

Outpatient coinsurance

This **deductible** is applied to **outpatient claims**.

20% for each **outpatient** consultation 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.

This **Benefits Schedule** has two broad sections; the first section covers **benefits** available anywhere within your chosen **tier** and **area of cover**.

The second section covers **benefits** available only within Tier 4. If your **medical condition** is an **emergency**, **tiers** do not apply and **treatment** is available at any medical provider throughout the United Arab Emirates.

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.

Network and tiers

Unless otherwise shown:

- Within the United Arab Emirates: your chosen **tier** will apply except if your **medical condition** is an **emergency**.
- Outside of the United Arab Emirates: The entire network will be available within your **area of cover**. **Tiers** do not apply.

Your **area of cover** and chosen **tier** are shown on your **Certificate of Insurance** and **Member ID Card**.

Your deductibles

Outpatient coinsurance

We'll apply your chosen level of **outpatient coinsurance**, as shown on your **Certificate of Insurance**, to **outpatient claims**.

Maternity coinsurance

We'll apply **our** maternity **coinsurance** to maternity **claims** under section 22 Pregnancy and childbirth.

Emergency dental, vision and hearing coinsurance

We'll apply this **coinsurance** to **claims** under some **benefits** within sections D19 Dental treatment and D20 Optical Care.

Out-of-tier coinsurance

We'll apply **our** 25% out-of-**tier coinsurance** if the **treatment** or services are received at a provider in the United Arab Emirates and:

- the provider is included in a **tier** that is not your chosen **tier**, or
- the provider is not in the **medical provider network**.

This out-of-**tier coinsurance** is applied to each **claim** after the deduction of any other applicable **coinsurance**. This **coinsurance** does not apply if the **treatment** or services received are needed due to an **emergency**, or if Tier 1 UAE is your chosen **tier**.

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. The **benefits** detailed below are available within your chosen **tier** and **area of cover**:

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**. This includes the overall DHA limit shown in the Tier 4 section.	**50,000 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**.	

*Additional **benefits** are available, refer to the Tier 4 section.*

*Out-of-**tier coinsurance** may apply*

3 Companion accommodation

No cover refer to the Tier 4 section.	Not covered

*Additional **benefits** are available, refer to the Tier 4 section.*

*Out-of-**tier coinsurance** may apply*

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
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	20% per OP consultation

*Out-of-**tier coinsurance** may apply*

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**. *i This section applies before any available **benefit** limit shown in 8 Physiotherapy and complementary medicine.*	Not covered

6 Cancer care

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

*i Out-of-**tier coinsurance** may apply*

7 Outpatient treatment

No cover refer to the Tier 4 section .	Not covered

*i Additional **benefits** are available, refer to the Tier 4 section.*

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 for up to 6 sessions in each **plan year**
Outpatient podiatry, osteopathic and chiropractic **treatment**, when a **medical practitioner** or **specialist** refers **you**.	Not covered
Outpatient traditional Chinese medicine, ayurvedic medicine, acupuncture and homeopathic **treatment**. *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**.*	Not covered

*i Additional **benefits** are available, refer to the Tier 4 section.*

*i Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	20% per OP consultation

*i Out-of-**tier coinsurance** may apply*

9 Psychiatric treatment

No cover refer to the Tier 4 section .	Not covered

*i Additional **benefits** are available, refer to the Tier 4 section.*

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 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* *26 Emergency treatment outside your area of cover*	Not covered

11 Congenital abnormalities

Benefit does not apply.	Not covered

12 HIV or AIDS

Benefit does not apply.	Not covered

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**.*	20% per OP consultation
*Out-of-**tier coinsurance** may apply*	

14 Terminal care

Benefit does not apply.	Not covered

15 Medical evacuation

Benefit	Cover
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**.	Not covered
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**.	Not covered
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	Not covered
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.	Not covered
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, 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. Cover is only available under this **benefit** if the **treatment** is covered under 23 Enhanced pregnancy and childbirth and **you** have completed any waiting periods shown in section 23.	Not covered

16 Local ambulance

Benefit	Cover
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* *D 7 Outpatient treatment* *D 9 Psychiatric treatment* *19 Dental treatment* *D 22 Pregnancy and childbirth*	✔ 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.	Not covered

18 Compassionate emergency visit

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

19 Dental treatment

Outpatient dental treatment for damage to **natural teeth** caused by an **accident** when: • your **dental** condition is not an **emergency**, • 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.	Not covered
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 your **dental** condition is not an **emergency** and **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
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 included in your **plan**.	Not covered
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**.	Not covered
Dental coinsurance	Not applicable

*Additional **benefits** are available, refer to the Tier 4 section.*

20 Optical care

No cover refer to the Tier 4 section.	Not covered

*Additional **benefits** are available, refer to the Tier 4 section.*

21 Wellness

No cover, refer to the Tier 4 section.	Not covered

*Additional **benefits** are available, refer to the Tier 4 section.*

22 Pregnancy and childbirth
For natural and assisted conception pregnancies

Costs of terminating a pregnancy when **medically necessary**.	✔ Paid in full

*Additional **benefits** are available, refer to the Tier 4 section.*

*Out-of-**tier coinsurance** may apply*

23 Enhanced benefit for pregnancy and childbirth
For natural and assisted conception pregnancies

Benefit does not apply.	Not covered

24 Hormone replacement therapy

Benefit does not apply.	Not covered

25 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**.	Not covered

26 Emergency treatment outside your area of cover

Inpatient and **daycare treatment** when your **medical condition** is an **emergency**. *__Outpatient coinsurance__ doesn't apply*	Not covered
Outpatient treatment when your **medical condition** is an **emergency**.	Not covered
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**.	Not covered

__We__ will only cover __you__ if the __emergency__ would be covered if __you__ were within your __area of cover__

If the **emergency** is due to pregnancy or childbirth and **you**'re 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**. Travel must not be against the advice of a **medical practitioner**, **specialist** or **nurse** at any time during your pregnancy.

27 Health management services

Access to our CARE team to receive tailored information and discuss any chronic condition and disease management.	Not included

28 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.	Not 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

What's covered only within Tier 4

The following section covers **benefits** available only within Tier 4. If your **medical condition** is an **emergency**, **tiers** do not apply and **treatment** is available throughout the United Arab Emirates.

D1 Overall DHA limit

We'll pay costs up to the overall DHA limit for each **member** in each **plan year**. This DHA limit is included within the overall **plan** limit shown in 1 Overall plan limit. If cover provided under this **plan** does not meet the minimum requirements of Dubai mandatory health coverage as stated by the Dubai Health Authority (DHA), **we**'ll pay the mandated costs from the overall DHA limit shown.	**41,000 USD**

D2 Inpatient and daycare treatment

All **inpatient treatment** needed for **acute medical conditions** that begin before the **member** is eight days old, if the pregnancy was the result of assisted conception.	✓ Paid in full
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 companion accommodation is needed in relation to this **benefit** and would normally be paid under section 3 Companion accommodation, it will be paid under this section instead.	✓ Paid in full

D3 Companion accommodation

Hospital accommodation costs for a companion to stay with the **member** if they're aged 17 or over, their condition is **critical** and they're receiving **inpatient treatment** that **we** cover.	✓ 30 USD for each night
Hospital accommodation costs for a parent or legal guardian to stay with the **member** if they're aged 16 or under and receiving **inpatient treatment** that **we** cover under 2 Inpatient and daycare treatment.	✓ 30 USD for each night

D7 Outpatient treatment

Surgical procedures.	✓ Paid in full
Outpatient pre-operative tests before **inpatient** or **daycare treatment** covered under 2 Inpatient and daycare treatment.	✓ Paid in full
Medical practitioners' and **specialists'** fees, prescribed drugs and dressings, X-rays, pathology and **diagnostic tests** and **procedures**.	✓ Paid in full
MRI, PET and CT scans.	✓ Paid in full
*i Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	20% per OP consultation

D8 Physiotherapy and complementary medicine

Outpatient physiotherapy when a **medical practitioner** or **specialist** refers **you**.	✓ Paid in full for up to 6 sessions in each **plan year**
*i Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	20% per OP consultation

D 9 Psychiatric treatment

Inpatient and **outpatient** psychiatric **treatment** and psychotherapy when your **medical condition** is an **emergency**.	✔ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	20% per OP consultation

D 19 Dental treatment

Outpatient dental treatment when your **dental** condition is an **emergency**.	✔ Paid in full
Emergency dental coinsurance	20%

D 20 Optical care

Visions aids, vision correction by surgery and hearing aids, when **treatment** is needed for a **medical condition** that is an **emergency**.	✔ Paid in full
Vision and hearing **coinsurance**	20%

D 21 Wellness

Members aged 17 or under: essential vaccinations as shown in the DHA's policies and updates. *Certain vaccinations for newborns are covered within section 22 Pregnancy and childbirth*	✔ Paid in full
Preventative services as shown in the DHA's policies and updates.	✔ Paid in full

D 22 Pregnancy and childbirth

For pregnancies resulting from natural and assisted conception

Costs for eight routine antenatal visits for each pregnancy, to include reviews, checks and tests as shown in the DHA's policies and updates. This **benefit** also includes antenatal vitamins and three antenatal 2D ultrasound scans for each pregnancy.	✔ Paid in full
Normal delivery costs including nursing fees and **hospital** accommodation.	✔ Paid up to 2,750 USD
Inpatient treatment for medical complications of maternity during pregnancy or childbirth if the **medical condition** is not an **emergency**.	
Costs of a **medically necessary** caesarean section if the **medical condition** is not an **emergency**. This **benefit** includes nursing fees and **hospital** accommodation.	
Maternity **coinsurance**	10%
Treatment for an **emergency** related to, or due to, a pregnancy. This **benefit** does not extend to the onset of a normal delivery.	✔ Paid in full
We will pay reasonable **hospital** accommodation costs for the newborn to stay with **you** immediately after childbirth.	
We'll 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 **plan**: • One physical examination • Vitamin K, hepatitis B and BCG vaccinations • Screening tests for PKU, congenital hypothyroidism and G6PD or sickle cell and congenital adrenal hyperplasia • 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. Where the newborn is an insured **member**, cover will still be provided under the insured mother's **plan**.	
Treatment needed for uninsured newborns. This **benefit** is only available for the first 30 days from birth, and cover will be provided under the insured mother's **plan**. This **benefit** extends to **hospital** accommodation costs for a companion to stay with the newborn. Costs will be limited to 30 USD for each night.	

D22 Pregnancy and childbirth Continued

For pregnancies resulting from natural and assisted conception

*The **benefit** limits apply for each pregnancy. Where a pregnancy spans more than one **plan year**, any **benefit** paid for **treatment** or services received in the **plan year** when the pregnancy began will be deducted from the **benefit** limit shown in the following **plan year**.*

*The **benefits** within this section do not extend to 3D or 4D ultrasound scans.*

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

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