

Aetna PioneerSM

1750-5000

2021 Benefits Schedule

EUR

For plans starting on or after
1 January 2021



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AetnaInternational.com

M093-6E-010121



At a glance



Overall plan limit

Aetna Pioneer 1750 Up to 1,400,000 EUR

Aetna Pioneer 2500 Up to 2,000,000 EUR

Aetna Pioneer 4000 Up to 3,200,000 EUR

Aetna Pioneer 5000 Up to 4,000,000 EUR



Annual excess

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

Aetna Pioneer 1750

Nil, 800 EUR, 1,600 EUR, 3,200 EUR or 6,400 EUR, as shown on your Certificate of Insurance.

Aetna 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.

Aetna Pioneer 1750

No outpatient coinsurance.

Aetna Pioneer 2500, 4000 and 5000

0%, 10% up to a maximum 1,600 EUR, 20% up to a maximum 3,200 EUR or 30% up to a maximum 4,000 EUR, 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 400 EUR 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 Aetna 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.

Outpatient coinsurance

We'll apply your 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.

	Aetna Pioneer SM 1750	Aetna Pioneer SM 2500	Aetna Pioneer SM 4000	Aetna Pioneer SM 5000
<p>1 Overall plan limits</p> <p>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.</p>	1,400,000 EUR	2,000,000 EUR	3,200,000 EUR	4,000,000 EUR
<p>2 Inpatient and daycare treatment</p> <p>Medical costs including intensive care, theatre, hospital accommodation, medical practitioners, specialists, anaesthetists, nursing, appliances and prescribed drugs and dressings.</p> <p>Kidney dialysis.</p> <p>MRI, PET and CT scans, X-rays, pathology and other diagnostic tests and procedures.</p> <p>Reconstructive surgery to restore natural function or appearance within 12 months of an accident or surgery.</p> <p>Speech and language therapy and occupational therapy as part of your inpatient treatment.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>✓</p> <p>Paid in full</p>	<p>✓</p> <p>Paid in full</p>	<p>✓</p> <p>Paid in full</p>	<p>✓</p> <p>Paid in full</p>
	<p>✓</p> <p>Up to a lifetime limit of 120,000 EUR</p>	<p>✓</p> <p>Up to a lifetime limit of 120,000 EUR</p>	<p>✓</p> <p>Up to a lifetime limit of 120,000 EUR</p>	<p>✓</p> <p>Up to a lifetime limit of 120,000 EUR</p>

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](#).

Aetna PioneerSM
1750

✓
Paid in full

Aetna PioneerSM
2500

✓
Paid in full

Aetna PioneerSM
4000

✓
Paid in full

Aetna PioneerSM
5000

✓
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.

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

✓
Paid in full

Not applicable

✓
Paid in full

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

✓
Paid in full

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

✓
Paid in full

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

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**.

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

Aetna PioneerSM 1750

✓
Paid in full
for up to 30 days
after you're discharged
or transferred

Not applicable

Aetna PioneerSM 2500

✓
Paid in full
for up to 60 days
after you're discharged
or transferred

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Aetna PioneerSM 4000

✓
Paid in full
for up to 90 days
after you're discharged
or transferred

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Aetna PioneerSM 5000

✓
Paid in full
for up to 120 days
after you're discharged
or transferred

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

6 Cancer care

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

	Aetna Pioneer SM 1750	Aetna Pioneer SM 2500	Aetna Pioneer SM 4000	Aetna Pioneer SM 5000
i Annual excess	Not applicable	Not applicable	Not applicable	Not applicable
i Outpatient coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

7 Outpatient treatment

Surgical procedures.

Outpatient pre-operative tests up to 72 hours before **inpatient** or **daycare treatment** covered under **2** [Inpatient and daycare treatment](#).

Medical practitioners' and **specialists'** fees, prescribed drugs and dressings, MRI scans, X-rays, pathology and **diagnostic tests and procedures**.

Kidney dialysis.

PET and CT scans.

	Aetna Pioneer SM 1750	Aetna Pioneer SM 2500	Aetna Pioneer SM 4000	Aetna Pioneer SM 5000
i Your chosen outpatient coinsurance applies, as shown on your Certificate of Insurance .	Not applicable	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR

8 Physiotherapy and complementary medicine

	Aetna Pioneer SM 1750	Aetna Pioneer SM 2500	Aetna Pioneer SM 4000	Aetna Pioneer SM 5000
Physiotherapy as part of inpatient or daycare treatment.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
<i>i</i> Outpatient coinsurance doesn't apply				
Post-hospitalisation outpatient physiotherapy. This benefit is available for 90 days after each inpatient or daycare admission.	✓ Paid up to 600 EUR			✓ Paid in full
Outpatient physiotherapy when a medical practitioner or specialist refers you.	Not covered	✓ Paid up to 1,200 EUR	✓ Paid up to 1,600 EUR	✓ Paid in full
<i>i</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.				
Outpatient podiatry, osteopathic and chiropractic treatment, when a medical practitioner or specialist refers you.	Not covered			✓ Paid up to 3,200 EUR
Outpatient traditional Chinese medicine, acupuncture, homeopathic treatment, and ayurvedic medicine including ayurvedic herbal preparations and therapies.	Not covered	✓ Paid up to 240 EUR	✓ Paid up to 600 EUR	✓ Paid up to 1,200 EUR
<i>i</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>i</i> Your chosen outpatient coinsurance applies, as shown on your Certificate of Insurance.	Not applicable	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR

9 Mental health

Up to 30 days **inpatient psychiatric treatment** and psychotherapy in the **plan year**.

Outpatient psychiatric treatment and psychotherapy.

i Annual excess

i Outpatient coinsurance

Aetna Mind – Provides **you** with tools for better mental health:

- Discover self-help solutions that develop positive mental health through educational well-being articles and how-to guides
- Receive direction and assistance with access to a range of evidence-based well-being tools for issues such as depression, anxiety, stress, substance abuse, chronic pain and sleep disturbance
- Access guided support from diagnosis to condition management.

Member Assistance Programme – Includes 24/7 real-time confidential support, as well as up to five in-person, telephonic or video counselling sessions annually for each work, personal or family issue.

Aetna PioneerSM 1750

✓
Paid up to
4,000 EUR

Not covered

Not applicable

Not applicable

Log in to your Health Hub Well-being section to find out how to access these services.

www.aetnainternational.com/members/login.do

Aetna PioneerSM 2500

✓
Paid up to
4,000 EUR

✓
Paid up to
800 EUR

Not applicable

Not applicable

Log in to your Health Hub Well-being section to find out how to access these services.

www.aetnainternational.com/members/login.do

Aetna PioneerSM 4000

✓
Paid up to
8,000 EUR

✓
Paid up to
1,600 EUR

Not applicable

Not applicable

Log in to your Health Hub Well-being section to find out how to access these services.

www.aetnainternational.com/members/login.do

Aetna PioneerSM 5000

✓
Paid in full

✓
Paid up to
8,000 EUR

Not applicable

Not applicable

Log in to your Health Hub Well-being section to find out how to access these services.

www.aetnainternational.com/members/login.do

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

This **benefit** does not extend to sight or hearing aids, personal protective equipment, furniture or any modifications to your personal or work environment.

i 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

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

Aetna PioneerSM
1750

Aetna PioneerSM
2500

Aetna PioneerSM
4000

Aetna PioneerSM
5000

✓
Paid up to
800 EUR

✓
Paid up to
800 EUR

✓
Paid up to
800 EUR

✓
Paid up to
1,600 EUR

Not applicable

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

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.

i We'll cover costs for an organ transplant for **congenital abnormalities** and any related medical conditions under section **13 Organ transplants**.

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

Aetna PioneerSM 1750

Not covered

Not applicable

Aetna PioneerSM 2500

Up to a **lifetime limit** of 20,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Aetna PioneerSM 4000

Up to a **lifetime limit** of 40,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Aetna PioneerSM 5000

Up to a **lifetime limit** of 80,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

12 HIV or AIDS

All treatment, including palliative treatment and care, for diagnosed HIV or AIDS and all related medical conditions.

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

Not covered

Not applicable

Paid up to 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Paid up to 8,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Paid up to 12,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

13 Organ transplants

Kidney, pancreas, liver, heart or lung transplants and any related treatment.

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

Paid in full

Not applicable

Paid in full

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Paid in full

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Paid in full

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

14 Terminal care

Palliative treatment and care for a medical condition which is diagnosed as terminal.

i 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

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

Aetna PioneerSM
1750

Aetna PioneerSM
2500

Aetna PioneerSM
4000

Aetna PioneerSM
5000

Not covered

✓
Paid in full

✓
Paid in full

✓
Paid in full

Not applicable

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

15 Medical evacuation

The costs to transport **you** to the nearest appropriate medical facility 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.

✓
Paid in full

✓
Paid in full

✓
Paid in full

✓
Paid in full

✓
Paid in full

✓
Paid in full

✓
Paid in full

✓
Paid in full

15 Medical evacuation
Continued

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 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 in any public or private medical facility, and
- **we** agree appropriate **treatment** is available in your chosen location.

We'll also cover costs for:

- Taxi transfers to and from the hotel on arrival and departure
- A taxi from the hotel to the **hospital**, and back, once a day for the duration of your evacuation
- Reasonable overnight accommodation costs including breakfast for the duration of your evacuation, until **you're** fit to travel back to your point of departure

This **benefit** also extends to these travel and accommodation costs for a companion or non-medical escort to accompany **you**, if your **medical condition** prevents **you** from travelling alone and you do not need a medical escort. The cost of their return economy class travel will only be covered from your point of departure.

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.

Aetna PioneerSM
1750

Aetna PioneerSM
2500

Aetna PioneerSM
4000

Aetna PioneerSM
5000

✓
Paid in full

✓
Paid in full

✓
Paid in full

✓
Paid in full

Optional benefit
Only applicable if selected

Optional benefit
Only applicable if selected

Optional benefit
Only applicable if selected

Optional benefit
Only applicable if selected

✓
Paid up to
1,600 EUR

✓
Paid up to
1,600 EUR

✓
Paid up to
1,600 EUR

✓
Paid up to
1,600 EUR

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**.

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** Mental health
- 11** Congenital abnormalities
- 12** HIV or AIDS
- 13** Organ transplants
- 14** Terminal care

Aetna PioneerSM
1750

✓
Paid in full

Aetna PioneerSM
2500

✓
Paid in full

Aetna PioneerSM
4000

✓
Paid in full

Aetna PioneerSM
5000

✓
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

✓
Paid in full

✓
Paid in full

✓
Paid in full

18 Compassionate emergency visit

Costs **you** have to pay for economy class travel 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**.

Aetna PioneerSM 1750

Not covered

Aetna PioneerSM 2500

Not covered

Aetna PioneerSM 4000

✓
Paid in full

Aetna PioneerSM 5000

✓
Paid in full

19 Dental treatment

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**.

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 in full

✓
Paid in full

✓
Paid in full

✓
Paid in full

Not covered

✓
Paid up to
400 EUR

✓
Paid up to
600 EUR

✓
Paid up to
1,200 EUR

Nil or
800 EUR or
1,600 EUR or
3,200 EUR or
16,400 EUR

Not applicable

Not applicable

Not applicable

Not applicable

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

Not applicable

Not applicable

Not applicable

Not applicable

i Your chosen annual excess applies, as shown on your *Certificate of Insurance*.

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

i Dental coinsurance

19 Dental treatment

Continued

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**.

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**.

Dental coinsurance

i Annual excess

i Outpatient coinsurance

Aetna PioneerSM
1750

Aetna PioneerSM
2500

Aetna PioneerSM
4000

Aetna PioneerSM
5000

Not covered

Not covered

Optional benefit
Only applicable if selected

Optional benefit
Only applicable if selected

Not covered

Not covered

✓
Paid up to
800 EUR
in each plan year

✓
Paid up to
1,200 EUR
in each plan year

Not applicable

Not applicable

25%

25%

Not applicable

Not applicable

Not applicable

Not applicable

Not applicable

Not applicable

Not applicable

Not applicable

20 Optical care

Prescription costs for:

- Contact lenses
- Spectacles
- Spectacle lenses
- Spectacle frames

You're also covered for one consultation and sight examination for the signs or symptoms, or management of, natural or non-medical degenerative sight disorders. This includes, but isn't limited to, myopia, hypermetropia and astigmatism.

Optical coinsurance

Not covered

Not covered

Not covered

✓
Paid up to
200 EUR

Not applicable

Not applicable

Not applicable

20%

21 Wellness

Vaccinations.

Routine health checks for non-communicable diseases. This includes cancer screening, cardiovascular examinations, neurological examinations and vital sign tests. This benefit extends to an **annual health assessment**.

Outpatient tests and diagnostic procedures for communicable diseases when you do not have signs or symptoms, and they are not received in relation to a diagnosed **medical condition**. This benefit extends to **outpatient** antibody tests.

Cover is available after you've had 90 days' continuous cover from the date that the benefit was first included in your plan.

One sight examination and one hearing examination in the **plan year**.

i Annual excess

i Outpatient coinsurance

	Aetna Pioneer SM 1750	Aetna Pioneer SM 2500	Aetna Pioneer SM 4000	Aetna Pioneer SM 5000
Vaccinations.	✓ Paid up to 120 EUR	✓ Paid up to 120 EUR	✓ Paid up to 200 EUR	✓ Paid up to 200 EUR
Routine health checks for non-communicable diseases. This includes cancer screening, cardiovascular examinations, neurological examinations and vital sign tests. This benefit extends to an annual health assessment .	Not covered	Not covered	✓ Paid up to 400 EUR	✓ Paid up to 800 EUR
Outpatient tests and diagnostic procedures for communicable diseases when you do not have signs or symptoms, and they are not received in relation to a diagnosed medical condition . This benefit extends to outpatient antibody tests.	Not covered	✓ Paid up to 240 EUR Maximum 56 EUR paid for each antibody test	✓ Paid up to 400 EUR Maximum 56 EUR paid for each antibody test	✓ Paid up to 400 EUR Maximum 56 EUR paid for each antibody test
Cover is available after you've had 90 days' continuous cover from the date that the benefit was first included in your plan.				
One sight examination and one hearing examination in the plan year .	Not covered	Not covered	✓ Paid up to 200 EUR	✓ Paid up to 200 EUR
i Annual excess	Not applicable	Not applicable	Not applicable	Not applicable
i Outpatient coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

22 Hormone replacement therapy

Hormone replacement therapy for symptoms of the menopause.

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

	Aetna Pioneer SM 1750	Aetna Pioneer SM 2500	Aetna Pioneer SM 4000	Aetna Pioneer SM 5000
Hormone replacement therapy for symptoms of the menopause.	Not covered	Not covered	✓ Paid up to 400 EUR	✓ Paid up to 400 EUR
i Your chosen outpatient coinsurance applies, as shown on your Certificate of Insurance.	Not applicable	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR	0% or 10% to max 1,600 EUR or 20% to max 3,200 EUR or 30% to max 4,000 EUR

23 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.

i Annual excess

Aetna PioneerSM
1750

Aetna PioneerSM
2500

Aetna PioneerSM
4000

Aetna PioneerSM
5000

✓
100 EUR
paid to you for
each night

✓
100 EUR
paid to you for
each night

✓
100 EUR
paid to you for
each night

✓
100 EUR
paid to you for
each night

Not applicable

Not applicable

Not applicable

Not applicable

24 Emergency treatment outside your area of cover

Inpatient and daycare treatment when your medical condition is an emergency.

i Outpatient coinsurance doesn't apply

Outpatient treatment when your medical condition is an emergency.

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

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.

i We will only cover you if the emergency would be covered if you were within your area of cover

✓
Paid up to
4,000 EUR

✓
Paid up to
12,000 EUR

✓
Paid up to
24,000 EUR

✓
Paid up to
40,000 EUR

Not covered

✓
Paid up to
400 EUR

✓
Paid up to
400 EUR

✓
Paid up to
400 EUR

Not applicable

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

0% or
10% to max 1,600 EUR or
20% to max 3,200 EUR or
30% to max 4,000 EUR

✓
Paid up to
400 EUR

✓
Paid up to
400 EUR

✓
Paid up to
400 EUR

✓
Paid up to
400 EUR

25 Health management services

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

Aetna PioneerSM
1750

Not included

Aetna PioneerSM
2500

Included

Aetna PioneerSM
4000

Included

Aetna PioneerSM
5000

Included

26 Aetna security assistance

24/7 personal security information and telephone support for all your travel safety queries. Log in to your HealthHub to find out more and to register for this service.

Included

Included

Included

Included

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

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Aetna Health Insurance Company of Europe DAC insures your plan, is regulated by the Central Bank of Ireland ref: C47511, and has its registered address at Alexandra House, The Sweepstakes, Ballsbridge, Dublin 4, Republic of Ireland.

Important: This is a non-US (United States) insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.

