

NAVIGATOR

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Aetna PioneerSM 1750-5000

Benefits Schedule

2019
USD

For plans starting on or after 1 July 2019

M091-4E-010719



Visit aetnainternational.com
Call +852-3017-4294
Email AsiaPacServices@aetna.com

At a glance



Overall plan limit

Aetna Pioneer 1750 Up to 1,750,000 USD

Aetna Pioneer 2500 Up to 2,500,000 USD

Aetna Pioneer 4000 Up to 4,000,000 USD

Aetna 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.

Aetna Pioneer 1750

Nil, 1,000 USD, 2,000 USD, 4,000 USD or 8,000 USD, 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 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 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 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	Aetna Pioneer SM 1750	Aetna Pioneer SM 2500	Aetna Pioneer SM 4000	Aetna Pioneer SM 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 .	 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
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.				

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.

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 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

✓
Paid in full

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

✓
Paid in full

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**.

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 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Aetna PioneerSM 4000

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

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Aetna PioneerSM 5000

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

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.

i Annual excess

Aetna PioneerSM
1750

✓
Paid in full

Not applicable

Aetna PioneerSM
2500

✓
Paid in full

Not applicable

Aetna PioneerSM
4000

✓
Paid in full

Not applicable

Aetna PioneerSM
5000

✓
Paid in full

Not applicable

7 Outpatient treatment

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

i 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

	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 750 USD			✓ Paid in full
Outpatient physiotherapy when a medical practitioner or specialist refers you.		✓ Paid up to 1,500 USD	✓ Paid up to 2,000 USD	✓ 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.	Not covered			
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
<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 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

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

i Outpatient coinsurance doesn't apply

Outpatient psychiatric treatment and psychotherapy.

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

Aetna PioneerSM 1750

Not covered

Not covered

Not applicable

Aetna PioneerSM 2500

✓
Paid up to
5,000 USD

✓
Paid up to
1,000 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Aetna PioneerSM 4000

✓
Paid up to
10,000 USD

✓
Paid up to
2,000 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Aetna PioneerSM 5000

✓
Paid in full

✓
Paid up to
10,000 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

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

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
1,000 USD

✓
Paid up to
1,000 USD

✓
Paid up to
1,000 USD

✓
Paid up to
2,000 USD

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

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 25,000 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Aetna PioneerSM 4000

Up to a **lifetime limit** of 50,000 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Aetna PioneerSM 5000

Up to a **lifetime limit** of 100,000 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

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 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

Paid up to 10,000 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Paid up to 15,000 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

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 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Paid in full

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Paid in full

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.

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

Not covered

Not applicable

Aetna PioneerSM
2500

✓
Paid in full

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Aetna PioneerSM
4000

✓
Paid in full

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

Aetna PioneerSM
5000

✓
Paid in full

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**.

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

✓
Paid in full

✓
Paid in full

✓
Paid in full

✓
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

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.

Aetna PioneerSM
1750

✓
Paid in full

Optional benefit
Only applicable if selected

✓
Paid up to
2,000 USD

Aetna PioneerSM
2500

✓
Paid in full

Optional benefit
Only applicable if selected

✓
Paid up to
2,000 USD

Aetna PioneerSM
4000

✓
Paid in full

Optional benefit
Only applicable if selected

✓
Paid up to
2,000 USD

Aetna PioneerSM
5000

✓
Paid in full

Optional benefit
Only applicable if selected

✓
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 due 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

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 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.

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
500 USD

✓
Paid up to
750 USD

✓
Paid up to
1,500 USD

i 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

i 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

i Dental coinsurance

Not applicable

Not applicable

Not applicable

Not applicable

19 Dental treatment
Continued

	Aetna Pioneer SM 1750	Aetna Pioneer SM 2500	Aetna Pioneer SM 4000	Aetna Pioneer SM 5000
<p>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.</p> <p>Cover is available after you've had 182 days' continuous cover from the date that the benefit was first included in your plan.</p>	Not covered	Not covered	Optional benefit Only applicable if selected	Optional benefit Only applicable if selected
<p>Major restorative dental treatment, including treatment for accidental damage to natural teeth when the damage is caused by eating. This benefit covers:</p> <ul style="list-style-type: none"> • 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 <p>Cover is available after you've had 182 days' continuous cover from the date that the benefit was first included in your plan.</p>	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%
i Annual excess	Not applicable	Not applicable	Not applicable	Not applicable
i Outpatient coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

20 Wellness

Members aged 18 or over: routine health checks including cancer screening, cardiovascular examinations, neurological examinations, vital sign tests and vaccinations.

Members aged 17 or under: routine health checks and vaccinations.

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

i Annual excess

Aetna PioneerSM 1750

Not covered

Not covered

Not covered

Not applicable

Aetna PioneerSM 2500

Not covered

Not covered

Not covered

Not applicable

Aetna PioneerSM 4000

✓
Paid up to
500 USD

Not covered

Not applicable

Aetna PioneerSM 5000

✓
Paid up to
1,000 USD

✓
Paid up to
250 USD

Not applicable

21 Hormone replacement therapy

Hormone replacement therapy for symptoms of the menopause.

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

Not covered

Not applicable

Not covered

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

✓
Paid up to
500 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

✓
Paid up to
500 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

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

✓
125 USD
paid to you for
each night

Not applicable

✓
125 USD
paid to you for
each night

Not applicable

✓
125 USD
paid to you for
each night

Not applicable

✓
125 USD
paid to you for
each night

Not applicable

23 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

Aetna PioneerSM
1750

✓
Paid up to
5,000 USD

Not covered

Not applicable

✓
Paid up to
500 USD

Aetna PioneerSM
2500

✓
Paid up to
15,000 USD

✓
Paid up to
500 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

✓
Paid up to
500 USD

Aetna PioneerSM
4000

✓
Paid up to
30,000 USD

✓
Paid up to
500 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

✓
Paid up to
500 USD

Aetna PioneerSM
5000

✓
Paid up to
50,000 USD

✓
Paid up to
500 USD

0% or
10% to max 2,000 USD or
20% to max 4,000 USD or
30% to max 5,000 USD

✓
Paid up to
500 USD

24 Health management services

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

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

Included

Included

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

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