Aetna Pioneer℠ 1750–5000

2021 Benefits Schedule

EUR

For plans starting on or after
1 January 2021

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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℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
1 Overall plan limits				
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**.	**1,400,000 EUR**	**2,000,000 EUR**	**3,200,000 EUR**	**4,000,000 EUR**
2 Inpatient and daycare treatment				
Medical costs including intensive care, theatre, **hospital** accommodation, **medical practitioners**, **specialists**, anaesthetists, nursing, **appliances** and prescribed drugs and dressings.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
Kidney dialysis.				
MRI, PET and CT scans, X-rays, pathology and other **diagnostic tests and procedures.**				
Reconstructive surgery to restore natural function or appearance within 12 months of an **accident** or surgery.				
Speech and language therapy and occupational therapy as part of your **inpatient treatment**.				
Medical services of a **nurse** that would have been part of your **inpatient** or **daycare treatment** when these are received in your home instead of in **hospital**.				
All **inpatient treatment** needed for **acute medical conditions** that begin before the **member** is eight days old, if the **member** was conceived by natural conception. Where **we** agree that parent accommodation is needed in relation to this **benefit** and would normally be paid under section 3 Parent accommodation, it will be paid under this section instead.	✓ Up to a **lifetime limit** of 120,000 EUR	✓ Up to a **lifetime limit** of 120,000 EUR	✓ Up to a **lifetime limit** of 120,000 EUR	✓ Up to a **lifetime limit** of 120,000 EUR

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

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

5 Rehabilitation

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

6 Cancer care

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
All **treatment** for, or related to, a diagnosed cancer. This includes **palliative treatment** and care.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Annual ***excess***	Not applicable	Not applicable	Not applicable	Not applicable
Outpatient coinsurance	Not applicable	Not applicable	Not applicable	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 800 EUR	✔ Paid up to 4,000 EUR	✔ Paid up to 12,000 EUR	✔ Paid in full
Medical practitioners' and **specialists'** fees, prescribed drugs and dressings, MRI scans, X-rays, pathology and **diagnostic tests and procedures**.	Not covered			✔ Paid in full
Kidney dialysis.	Not covered			✔ Paid in full
PET and CT scans.	Not covered	✔ Paid in full	✔ Paid in full	✔ Paid in full
Your chosen ***outpatient coinsurance*** *applies, as shown on your* ***Certificate of Insurance****.*	Not applicable	0% or 10% to max 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℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
Physiotherapy as part of **inpatient** or **daycare treatment**. *Outpatient coinsurance doesn't apply*	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Post-hospitalisation **outpatient** physiotherapy. This **benefit** is available for 90 days after each **inpatient** or **daycare** admission.	Paid up to 600 EUR	Paid up to 1,200 EUR	Paid up to 1,600 EUR	✔ Paid in full
Outpatient physiotherapy when a **medical practitioner** or **specialist** refers **you**. *We reserve the right to seek further information from your **medical practitioner** or therapist if **you** received further **treatment** after **you**'ve completed six sessions.*	Not covered			✔ Paid in full
Outpatient podiatry, osteopathic and chiropractic **treatment**, when a **medical practitioner** or **specialist** refers **you**.	Not covered			Paid up to 3,200 EUR
Outpatient traditional Chinese medicine, acupuncture, homeopathic **treatment**, and ayurvedic medicine including ayurvedic herbal preparations and therapies. *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	Paid up to 240 EUR	Paid up to 600 EUR	Paid up to 1,200 EUR
*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

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
Up to 30 days **inpatient** psychiatric **treatment** and psychotherapy in the **plan year**.	✓ Paid up to 4,000 EUR	✓ Paid up to 4,000 EUR	✓ Paid up to 8,000 EUR	✓ Paid in full
Outpatient psychiatric **treatment** and psychotherapy.	Not covered	✓ Paid up to 800 EUR	✓ Paid up to 1,600 EUR	✓ Paid up to 8,000 EUR
Annual excess	Not applicable	Not applicable	Not applicable	Not applicable
Outpatient coinsurance	Not applicable	Not applicable	Not applicable	Not applicable
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.	Log in to your Health Hub Well-being section to find out how to access these services. www.aetnainternational.com/members/login.do	Log in to your Health Hub Well-being section to find out how to access these services. www.aetnainternational.com/members/login.do	Log in to your Health Hub Well-being section to find out how to access these services. www.aetnainternational.com/members/login.do	Log in to your Health Hub Well-being section to find out how to access these services. www.aetnainternational.com/members/login.do
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.				

10 Durable medical equipment
including prosthetic and orthotic supplies

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
We'll cover costs for: • Items a **medical practitioner** or **specialist** prescribes which are needed to deliver prescribed drugs and apply dressings • Buying and fitting of devices or items **medically necessary** for **treatment** including spinal supports, orthopaedic braces and air cast boots • The rental or initial purchase of crutches or a wheelchair if **medically necessary** • The initial buying and fitting of external prostheses needed after surgery, including artificial eyes and limbs • The buying and fitting of **medically necessary** orthotic supplies, including insoles and orthotic supports This **benefit** does not extend to sight or hearing aids, personal protective equipment, furniture or any modifications to your personal or work environment. *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 800 EUR	✓ Paid up to 800 EUR	✓ Paid up to 800 EUR	✓ Paid up to 1,600 EUR
*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

11 Congenital abnormalities

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
All **treatment** for diagnosed **congenital abnormalities** and any **related medical conditions**. This includes **palliative treatment** and care for a **congenital abnormality** or any **related medical condition**. *We'll cover costs for an organ transplant for **congenital abnormalities** and any **related medical conditions** under section 13 Organ transplants.*	Not covered	✓ Up to a **lifetime limit** of 20,000 EUR	✓ Up to a **lifetime limit** of 40,000 EUR	✓ Up to a **lifetime limit** of 80,000 EUR
*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

12 HIV or AIDS

All **treatment**, including **palliative treatment** and care, for diagnosed HIV or AIDS and all **related medical conditions**.	Not covered	✓ Paid up to 4,000 EUR	✓ Paid up to 8,000 EUR	✓ Paid up to 12,000 EUR
*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

13 Organ transplants

Kidney, pancreas, liver, heart or lung transplants and any related **treatment**.	✓ Paid in full	✓ Paid in full	✓ Paid in full	✓ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 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

14 Terminal care

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
Palliative treatment and care for a **medical condition** which is diagnosed as **terminal**. *If the costs are related to a **medical condition we** cover under the following sections, **we**'ll cover these within the **benefit** limits of that section:* 6 *Cancer care* 11 *Congenital abnormalities* 12 *HIV or AIDS*	Not covered	✔ Paid in full	✔ Paid in full	✔ Paid in full
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 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**.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Economy class travel costs for **you** to go back to your choice of your **country of residence**, or your **home country**, after your **emergency** 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

15 Medical evacuation
Continued

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
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**.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
The costs to transport **you** to appropriate medical facilities to receive **treatment** when your **medical condition** is not an **emergency**. **We**'ll cover costs for return economy class travel to a location of your choice within your **area of cover** if: • **we** agree appropriate **treatment** is not available locally 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.	**Optional benefit** Only applicable if selected ✔ Paid up to 1,600 EUR	**Optional benefit** Only applicable if selected ✔ Paid up to 1,600 EUR	**Optional benefit** Only applicable if selected ✔ Paid up to 1,600 EUR	**Optional benefit** Only applicable if selected ✔ Paid up to 1,600 EUR

16 Local ambulance

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

Costs of the appropriate type of ambulance needed to transport **you** to the nearest available and appropriate local **hospital** because of an **emergency**.

*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*

17 Mortal remains

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

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.

18 Compassionate emergency visit	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
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**.	Not covered	Not covered	✔ Paid in full	✔ 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.	✔ Paid in full	✔ Paid in full	✔ Paid in full	✔ Paid in full
Outpatient dental treatment for damage to **natural teeth** caused by an **accident**, except when the damage is caused by eating. Cover is only available when **you** receive **treatment** for the accidental damage within 10 days of the **accident**. This **benefit** also includes one follow-up consultation within 30 days of the **accident**.	Not covered	✔ Paid up to 400 EUR	✔ Paid up to 600 EUR	✔ Paid up to 1,200 EUR
*Your chosen annual excess applies, as shown on your **Certificate of Insurance**.*	Nil or 800 EUR or 1,600 EUR or 3,200 EUR or 16,400 EUR	Not applicable	Not applicable	Not applicable
*Your chosen **outpatient coinsurance** applies, as shown on your **Certificate of Insurance**.*	Not applicable	0% or 10% to max 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
Dental coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

19 Dental treatment
Continued

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
Routine **outpatient dental treatment**, including **treatment** for accidental damage to **natural teeth** when the damage is caused by eating. This **benefit** covers **dental** examinations, scraping, cleaning and polishing, X-rays, composite fillings and simple non-surgical extractions only. Cover is available after **you**'ve had 182 days' continuous cover from the date that the **benefit** was first included in your **plan**.	Not covered	Not covered	**Optional benefit** Only applicable if selected	**Optional benefit** Only applicable if selected
Major restorative **dental treatment**, including **treatment** for accidental damage to **natural teeth** when the damage is caused by eating. This **benefit** covers: • Surgical extractions, including wisdom teeth • Root canal **treatment** • The cost to supply, fit and repair crowns, bridges and dentures • X-rays needed to support major restorative **dental treatment** • Gum **treatment** Cover is available after **you**'ve had 182 days' continuous cover from the date that the **benefit** was first included in your **plan**.	Not covered	Not covered	✓ Paid up to 800 EUR in each plan year	✓ Paid up to 1,200 EUR in each plan year
Dental coinsurance	Not applicable	Not applicable	25%	25%
Annual ***excess***	Not applicable	Not applicable	Not applicable	Not applicable
Outpatient coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

20 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.	Not covered	Not covered	Not covered	✓ Paid up to 200 EUR
Optical **coinsurance**	Not applicable	Not applicable	Not applicable	20%

21 Wellness

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 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. Cover is available after you've had 90 days' continuous cover from the date that the benefit was first included in your plan.	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
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
*Annual **excess***	Not applicable	Not applicable	Not applicable	Not applicable
Outpatient coinsurance	Not applicable	Not applicable	Not applicable	Not applicable

22 Hormone replacement therapy

Hormone replacement therapy for symptoms of the menopause.	Not covered	Not covered	✓ Paid up to 400 EUR	✓ Paid up to 400 EUR
*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

	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
We'll pay **you** for each night **you** stay in a **hospital** for **inpatient treatment**: • if the **inpatient treatment** and **hospital** accommodation **you** receive during your stay are provided free of charge, and • **we** would otherwise cover the **treatment** or services **you** receive during your stay under this **plan**. We'll pay for a maximum of 20 nights in the **plan year**.	✓ 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
*Annual **excess***	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**. *Outpatient coinsurance doesn't apply*	✓ Paid up to 4,000 EUR	✓ Paid up to 12,000 EUR	✓ Paid up to 24,000 EUR	✓ Paid up to 40,000 EUR
Outpatient treatment when your **medical condition** is an **emergency**.	Not covered	✓ Paid up to 400 EUR	✓ Paid up to 400 EUR	✓ Paid up to 400 EUR
*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
Costs of the appropriate type of ambulance needed to transport **you** to the nearest appropriate local **hospital.** This **benefit** is only available when your **medical condition** is an **emergency**. *We will only cover **you** if the **emergency** would be covered if **you** were within **your area of cover***	✓ Paid up to 400 EUR	✓ Paid up to 400 EUR	✓ Paid up to 400 EUR	✓ Paid up to 400 EUR

25 Health management services	Aetna Pioneer℠ 1750	Aetna Pioneer℠ 2500	Aetna Pioneer℠ 4000	Aetna Pioneer℠ 5000
Access to **our** CARE team to receive tailored information and discuss any **chronic** condition and disease management	Not included	✔ Included	✔ Included	✔ 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 does not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. Your plan documents contain a description of benefits, exclusions, limitations and conditions of coverage. For more information, refer to **www.AetnaInternational.com**.

If coverage provided by this policy violates or will violate any United States (US), United Kingdom, United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Asset Control (OFAC) license. For more information on OFAC, visit **www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

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.

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