GlobalHealth®

This Benefit Overview provides a summary of the cover we provide under each plan. Cover is subject to our policy terms and conditions. In the event of any discrepancy, the policy terms and conditions shall prevail. All limits and monetary amounts shall in all instances be in US$. GlobalHealth Plans are underwritten by Pioneer Life Inc.

Policy Limit

	Global PH400	Global PH350	Global PH100
Policy Limit per Insured Individual	$2,000,000 per year	$2,000,000 per year	$250,000 per Disability per Lifetime
Hospitalization and Outpatient			
Room and Board including general nursing care	Fully Covered	Fully Covered	Up to $250 per day
Parental Accommodation (as an added bed, same room)	Fully Covered	Fully Covered	No Cover
Theatre fees; intensive care; X-rays; laboratory tests; medicines and drugs; blood and plasma; surgical appliances; rental of wheel chairs; standard prosthetic devices	Fully Covered	Fully Covered	Fully Covered
Surgeon's Fees including pre- and post-surgical services	Fully Covered	Fully Covered	$15,000 per Disability
Anesthetist Fees as charged	Fully Covered	Fully Covered	up to 30% of the eligible Surgeon's Fees
Professional Fees including physician, specialist, radiologist, physiotherapist, and pathologist fees	Fully Covered	Fully Covered	Fully Covered
Private Nursing			
In-hospital, when certified medically necessary by an attending physician	Fully Covered	Fully Covered	Fully Covered
Home nursing by a registered nurse immediately following hospitalization and on the recommendation of the attending surgeon or specialist	Up to 30 days per Disability	Up to 30 days per Disability	No Cover
Organ Transplant			
Transplant of heart, liver, kidney, or bone marrow	$200,000 per Disability	$200,000 per Disability	$100,000 per Disability
Emergency Benefits			
Local Ambulance to hospital	Fully Covered	Fully Covered	Fully Covered
Emergency room treatment	Fully Covered	Fully Covered After $100 Deductible per admission	Fully Covered
Dental Treatment for up to 72 hours following accidental damage to sound natural teeth	Fully Covered	Fully Covered	No Cover
Mental or Nervous Disorders			
Inpatient treatment up to a per-person limit of	$5,000/year $10,000 per lifetime benefit	$5,000/year $10,000 per lifetime benefit	No Cover
AIDS/HIV Coverage			
Coverage will apply when signs or symptoms present for the first time after five (5) years continuous coverage under the Policy and any renewal thereof, to an all-inclusive limit of	$100,000 per lifetime benefit	$100,000 per lifetime benefit	$25,000 per lifetime benefit

PIONEER LIFE INC.
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Pre-Hospitalization			
Outpatient treatment incurred 30 days prior to a Confinement for a covered Disability	Fully Covered	1 outpatient visit	1 outpatient visit
Post-Hospitalization			
Covers normal follow-up treatment for up to 90 days following hospitalization up to the maximum limits for organ transplants, surgeon's fees, and anaesthetist fees:			
Physicians and specialists office visits	Fully Covered	Fully Covered	Fully Covered
Physiotherapist, chiropractor, and acupuncturist when certified necessary by an attending physician	Fully Covered	Fully Covered	Fully Covered
Prescribed medicines, dressings, x-rays, diagnostic laboratory tests, and surgical appliances	Fully Covered	Fully Covered	Fully Covered
Hospice or Palliative Treatment			
Hospice / Palliative Care	$5,000 per lifetime benefit	$5,000 per lifetime benefit	No Cover
Outpatient Benefits			
Physicians and specialists consultations	Fully Covered	No Cover	No Cover
Physiotherapist when certified necessary by an attending physician	Fully Covered	No Cover	No Cover
Prescribed medicines, dressings, x-rays, diagnostic laboratory tests, and surgical appliances	Fully Covered	No Cover	No Cover
Complementary Medicine			
Physiotherapist without certification from an attending physician, chiropractor, acupuncturist, osteopath, homeopath, bone setter, and Chinese medicine practitioner	$500 per year	No Cover	No Cover
Maternity Benefits			
Prenatal and postnatal services, costs of delivery including all hospital and professional fees, severe Complications of Pregnancy as specified in Policy, and up to seven days of nursery care	$8,000 per pregnancy	$6,000 per pregnancy	No Cover
Optional Dental			
Routine Dental Treatment Examinations, Tooth cleaning, Normal compound fillings, Porcelain Crowns, Extractions, Sealants	$700 per year	$700 per year	No Cover
Major Restorative Dental Work Removal of impacted, buried or unerupted teeth, Removal of roots, Root Canal Treatment, Removal of solid odontomes, Apicectomy, New or repair of Bridge Work, New or repair of Crowns, New or repair of Upper and Lower Dentures	$1,500 per year	$1,500 per year	No Cover

GHPH Benefits 2013/07

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