Plan for Individuals

Latin America & Caribbean

Gold Plan

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46.03.504.1-LAC E (8/20)

Plan features

	In USA In Network	In USA Out of Network	Outside of USA
Maximum annual aggregate limit We will provide coverage for the treatment of medical conditions that first manifest themselves during any period of coverage and where treatment is actually given during the current period of coverage or where such medical conditions have manifested themselves prior to the date of entry but have been declared to and accepted by us in writing. All costs incurred must be medically necessary and subject to reasonable and customary charges, based on the average treatment costs applicable to the region in which the treatment was received, as determined by us. The following benefits are covered subject to any specific limits set out under each benefit and subject to the payment of all coinsurance and deductible(s) as set out in section headed limits of coverage in your certificate and/or as stated in your schedule of coverage. Benefits are per enrolled person, per period of cover.	U.S. $2,500,000	U.S. $2,500,000	U.S. $2,500,000
Coinsurance maximum The maximum amount each enrolled person will have to pay as coinsurance per period of coverage. After this maximum, for which you are liable, is reached, the policy will pay benefits at 100%. Deductible payments do not contribute to these limits. Eligible treatment requiring precertification, which is not precertified, will not be subject to the coinsurance limit.	N/A	U.S. $4,000	N/A
Inpatient and day patient treatments Accommodation, limited to a standard private room and associated charges, including admittance to the intensive care unit as an inpatient or day patient and charges for nursing by a qualified nurse, facility fees and other charges incurred for the treatment of a medical condition. Medical practitioner fees including consultations, specialist fees as an inpatient or day patient, and anesthetist fees. Diagnostic and surgical procedures including pathology, X-rays, CT and MRI scans.	100%	80%	100%

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Outpatient surgery Covered expenses include charges for services and supplies furnished in connection with an outpatient surgery made by an office-based surgical facility of a physician, a surgery center or the outpatient department of a hospital. The following outpatient surgery expenses are covered: i) Services and supplies provided by the hospital or surgery center on the day of the procedure. ii) The operating physician's services for performing the procedure, related pre- and post-operative care and administration of anesthesia.	100%	80%	100%
Convalescence Admission to a convalescent facility must follow treatment for a medical condition where the enrolled person was confined to a hospital as an inpatient for at least three consecutive days, and where a physician confirms in writing that convalescence is required. Admission to a convalescent facility must be made within 14 days of discharge from hospital. Such treatment would cover: i) Use of special treatment rooms. ii) Physical, occupational or speech therapy fees. iii) Other services usually given by a convalescent facility including qualified nursing care but not including private or special nursing or specialist physician services. Benefit limit per medical condition: 30 days	100%	80%	100%
Home health care Treatment made in the home of the enrolled person. Such treatment will cover: i) Part-time or intermittent care by a qualified nurse. ii) Part-time or intermittent services of a home health care provider. iii) Laboratory services. Each visit by a qualified nurse or home health care provider of up to four hours duration is classed as one visit. Each visit of more than four hours duration will be classified as two or more visits; each visit allows up to four hours of services provided. All treatment under this benefit is conditional upon precertification by us. Without our written consent prior to treatment, the insurer will not be liable to pay any benefit. Benefit limit per medical condition: 60 visits	100%	80%	100%

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Reconstructive surgery Reconstructive surgery following an accident or following surgery for an eligible medical condition provided such surgery is carried out at a medically suitable stage after the accident or surgery has occurred. Surgery, in any event, must be carried out within 365 days from the date of the accident or medical condition subject to policy coverage being maintained throughout such period.	100%	80%	100%
Psychiatric treatment (inpatient) All treatment under this benefit is conditional upon precertification from us and must at all times be administered under the direct control of a registered psychiatric physician. Without our written confirmation prior to such treatment, insurer will not be liable to pay any benefit. However, initial consultation with a physician (not a psychiatric physician), which results in a psychiatric referral, is covered without the requirement for precertification. Benefit limit per policy year: 28 days	100%	80%	100%
Outpatient psychiatric All treatment under this benefit is conditional upon precertification from us and must at all times be administered under the direct control of a registered psychiatric physician. Without our written confirmation prior to such treatment, insurer will not be liable to pay any benefit. However, initial consultation with a physician (not a psychiatric physician), which results in a psychiatric referral, is covered without the requirement for precertification. Benefit limit per policy year: 30 visits	100%	80%	100%

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Newborn illness Inpatient treatment of an acute medical condition being suffered by a newborn baby that manifests itself within 30 days following birth. Complications arising as a result of assisted conception including, but not limited to, premature or multiple births are excluded from this benefit. In circumstances where a congenital anomaly manifests itself in a newborn baby, coverage will be excluded under this benefit and payable under the benefit for congenital anomalies. Following the 30 day newborn benefit period, excepting any medical conditions occurring or manifesting themselves during the 30 day period immediately following birth, the member's dependent will be eligible for coverage up to the full provision of this policy. Coverage is subject to the child being included under his/her parent(s) policy and all premiums due being paid in full. Benefit limit per lifetime: U.S. $250,000	100%	80%	100%
Congenital conditions Treatment of congenital anomalies that manifest themselves after your date of entry or which manifest themselves in a dependent child within 12 months of birth. This benefit excludes any hereditary medical conditions. Benefit limit per lifetime: U.S. $500,000	100%	80%	100%
Oncology Treatment given for cancer received as an inpatient, day patient or outpatient.	100%	80%	100%
Organ transplant Covered transplants are: a) Heart b) Heart/lung c) Lung d) Kidney e) Kidney/pancreas f) Liver g) Allogenic bone marrow h) Autologous bone marrow Donor expenses are covered under this benefit. Benefit limit per organ transplant operation per lifetime: U.S. $500,000	100%	80%	100%

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Accidental damage to teeth Treatment received in an emergency room in a hospital within seven days of incurring accidental damage caused to sound, natural teeth that were firmly attached to the jaw bone at the time of injury, when given by a physician or dental practitioner.	100%	80%	100%
AIDS Medical expenses that arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof. Expenses are limited to pre- and post-diagnosis consultations, routine checkups for this condition, drugs and dressings (except experimental or those unproven), room and board and qualified nurse fees. The benefit provided in respect of AIDS is not for an acute medical condition and this is provided solely and purely as an extension of coverage only in relation to AIDS. Benefit limit per lifetime: U.S. $250,000	100%	80%	100%
Prosthesis An artificial body part under this policy; prosthesis will be limited to an artificial limb or eye. Benefit limit per lifetime: U.S. $10,000	100%	80%	100%
Private room and board Charges made by a medical facility for the provision of a room, bed and other necessary services made on a daily or weekly standard private room rate.	100%	80%	100%
ICU Charges for care received as an inpatient confined in the Intensive Care Unit of a hospital. Room rate limit: U.S. $4,000	100%	80%	100%
Parent accommodation Hospital accommodation costs in respect of a parent or legal guardian staying with an enrolled person who is under 18 years of age and is admitted to a hospital as an inpatient.	100%	80%	100%

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Medical evacuation Evacuation costs of an enrolled person in the event of emergency treatment not being readily available at the place of the incident, to the nearest appropriate medical facility, for the purpose of admission to a medical facility as an inpatient or day patient. This benefit is extended to cover the costs of one other person to travel with the member as an escort, if medically necessary. **Evacuation – additional travel expense** Reasonable pre- and post-hospitalization costs following an evacuation to include: i) Travel to and from medical appointments when treatment is being received as a day patient (up to U.S. $25 per day) ii) For an accompanying person to travel to and from the hospital to visit the member following admission as an inpatient. (up to U.S. $25 per day) iii) Non-hospital accommodation for immediate pre- and post-hospital admission periods provided that the member is under the care of a specialist (up to U.S. $50 per day) iv) Economy class airline ticket to return the member and one other person who has traveled as an escort to the country of residence or to the country where evacuation occurred. Benefit limit for additional travel expenses per medical evacuation: U.S. $10,000	100%	100%	100%
Air and ground ambulance Transportation costs to and from a hospital by the most appropriate transport method (including licensed air ambulance but excluding all other forms of air transportation) in the event of an emergency where considered medically necessary by a physician or specialist physician. Costs for air ambulance, which has not been precertified by us, are limited to U.S. $2,000 per incident.	100%	100%	100%
Mortal remains In the event of death from an eligible medical condition: i)Costs of transportation of body or ashes of an enrolled person to his/her country of nationality or country of residence; or ii) Burial or cremation costs at the place of death in accordance with reasonable and customary practice. Benefit limit: U.S. $10,000	100%	100%	100%

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Outpatient treatment charges Medical practitioner, specialist, consultant and nursing fees, outpatient charges including diagnostic and surgical procedures including pathology, X-rays (but excluding CT and MRI scans), drugs and dressings and appliances (e.g., pacemaker) prescribed by a medical practitioner or specialist. Physiotherapy on referral by a medical practitioner is restricted to 10 sessions per medical condition, after which it must be further reviewed by a specialist. A medical report will be required for outpatient physiotherapy after 10 sessions. A referral letter/report must be submitted with the first claim for such treatment. Alternative treatment administered by registered chiropractors, osteopaths, homeopaths, podiatrists and acupuncturists when given under the direct control of and following referral by a medical practitioner or specialist. Alternative treatment is limited to 10 sessions in aggregate per medical condition.	100%	80%	100%
CT and MRI scans Scans received as an inpatient, day patient or outpatient. All treatment under this benefit is conditional upon precertification from us. Without our written confirmation prior to such treatment, the insurer will not be liable to pay any benefit.	100%	80%	100%
Outpatient drugs and dressings Essential drugs, medicines and dressings prescribed by a physician or specialist physician and which are not available without a prescription. Limit does not apply to Oncology and Routine Management of Chronic Conditions. Benefit limit: U.S. $4,000 per policy year	100%	80%	100%
Hormone replacement therapy Physician or specialist physician consultations and the cost of prescribed implants, patches or tablets when treatment is prescribed solely for the purpose of hormone imbalance. Coverage is provided for female menopause that has been induced artificially and/or through early onset (by early onset we mean prior to age 40 years). Coverage does not extend to treatment of hormone imbalance due to naturally occurring menopause.	100%	80%	100%

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Routine management of chronic conditions Routine checkups, drugs and dressings prescribed for management of the condition, hospital accommodation nursing, renal dialysis, surgery and palliative treatment of chronic conditions (excluding cancer). Costs for the treatment of cancer are covered under the oncology benefit.	100%	80%	100%
Non-preauthorized treatment Inpatient/day patient and emergency treatment.	50%	50%	50%
Non-emergency care in emergency room Reimbursement percentage per medical condition.	50%	50%	50%
Maternity (10 month waiting period applies) Costs associated with routine pregnancy and childbirth and any related condition. Benefits are limited to childbirth, pre- and postnatal checkups and delivery costs, including caesarean section costs required on medical grounds. All costs relating to a pregnancy and/or childbirth following assisted conception will be limited to this benefit. When the Maternity option is purchased, all enrolled female members (including dependents under the age of 18) are eligible for this benefit. This benefit is payable after the first 10 months from the commencement date or date of entry, whichever is the later. Benefit limit – normal delivery: U.S. $5,000 per pregnancy Benefit limit – caesarian delivery required on medical grounds: U.S. $9,500 per pregnancy Voluntary caesarian delivery is covered up to the normal delivery benefit limit.	100%	80%	100%
Complications of pregnancy (10 month waiting period applies) Treatment of a medical condition arising during the antenatal stages of pregnancy, or a medical condition arising during childbirth and which requires a recognized obstetric procedure. All enrolled female members (including dependents under the age of 18) are eligible for this benefit. This benefit is payable after the first 10 months from the commencement date or date of entry, whichever is the later. Complications arising as a result of assisted conception including, but not limited to, premature or multiple births are excluded from this benefit.	100%	80%	100%

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Newborn accommodation Hospital accommodation costs relating to a newborn baby (up to 16 weeks old) to accompany his or her mother (being an enrolled person) while she is receiving treatment as an inpatient in a hospital.	100%	80%	100%
Wellness	No coverage	No coverage	No coverage
Colorectal screening Deemed medically necessary due to: • Being age 50 and over; • A family history of familial adenomatous polyposis; • Hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps; • Chronic inflammatory bowel disease; or • A background, ethnicity or lifestyle that the physician believes puts the covered person at elevated risk for colorectal. When prescribed by a physician, colorectal cancer screening and laboratory testing includes: • Screening with annual fecal occult blood tests (3 specimens); • Flexible sigmoidoscopy every 5 years; • Colonoscopy every 10 years; • Double contrast barium enema every 5 years; or • Any combination of the most reliable, medically recognized screening tests available as may be determined by the physician. Benefit limit: U.S. $2,500 per screening Deductible is waived for wellness expenses	90%	70%	90%
Deductible options The amount payable by an enrolled person in respect of expenses incurred for treatment before any benefits are paid under this certificate for each period of coverage. Please refer to your Schedule of Coverage for the deductible that applies to your plan.	U.S. $500 U.S. $1,000 U.S. $2,000 U.S. $5,000 U.S. $10,000 U.S. $20,000	U.S. $500 U.S. $1,000 U.S. $2,000 U.S. $5,000 U.S. $10,000 U.S. $20,000	U.S. $500 U.S. $1,000 U.S. $2,000 U.S. $5,000 U.S. $10,000 U.S. $20,000

For more information, visit
AetnaInternational.com
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