

Overview of Benefits

Schedule of Benefits

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Lifetime Maximum	Unlimited	Unlimited	Unlimited
The Percentage of Covered Expenses the Plan Pays	100%	85%	60% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	Not Applicable	150% of Medicare Rates
<p>Maximum Reimbursable Charge is determined based on the lesser of the Provider's normal charge for a similar service or supply; or a percentage of Charges made by Providers of such service or supply in the geographic area where the service is received. These Charges are compiled in a database We have selected. Note: The Provider may bill You for the difference between the Provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Deductibles and Coinsurance.</p>			
Calendar Year Medical Deductible			
Individual	\$0	\$350	\$700
Family Maximum	\$0	2 times the individual Deductible	2 times the individual Deductible
<p>Family members meet only their individual Deductible and then their claims will be covered under the Plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the Plan Coinsurance.</p>			
Out-of-Pocket Maximum			
Individual	n/a	\$1,750	\$4,650
Family Maximum	n/a	2 times the individual Out-of-Pocket Maximum	2 times the individual Out-of-Pocket Maximum
<p>Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.</p>			
Physician's Services			
Physician's Office Visit - Primary Care Physician	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Office Visit – Specialist	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Surgery Performed In the Physician's Office	100%	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Second Opinion Consultations (provided on a voluntary basis)	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Allergy Treatment/Injections	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Preventive Care			
Routine Preventive Care – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Immunizations – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Travel Immunization Calendar Year Maximum \$500	100%	100%, No Deductible	100%, No Deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Lead Poisoning Screening Tests For Children under age 6	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Inpatient Hospital – Facility/Professional Charges			
Bed and Board Charges	100%	85%, After Deductible	60%, After Deductible
Physician's Visits/Consultations	100%	85%, After Deductible	60%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%	85%, After Deductible	60%, After Deductible
Inpatient Services at Other Health Care Facilities			
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum of 120 day limit.	100%	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Ambulatory Surgical Services Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100% 100%	85%, After Deductible 85%, After Deductible	60%, After Deductible 60%, After Deductible
Emergency and Urgent Care Services Hospital Emergency Room Outpatient Professional Services (radiology, pathology and ER Physician) Urgent Care Facility X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit) X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit Ambulance	100% 100% 100% 100% 100%	85%, After Deductible 85%, After Deductible 85%, After Deductible 85%, After Deductible 85%, After Deductible	If You have a true Emergency Medical Condition, the benefits will be paid at the U.S. Participating Provider Rate 60%, After Deductible 60%, After Deductible 60%, After Deductible 60%, After Deductible 60%, After Deductible
Laboratory and Radiology Services (includes pre-admission testing) Inpatient Facility Outpatient Facility Independent X-ray and/or Lab Facility	100% 100% 100%	85%, After Deductible 85%, After Deductible 85%, After Deductible	60%, After Deductible 60%, After Deductible 60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)			
Inpatient Facility	100%	85%, After Deductible	60%, After Deductible
Outpatient Facility	100%	85%, After Deductible	60%, After Deductible
Independent Facility	100%	85%, After Deductible	60%, After Deductible
Maternity Care/Obstetrical Services			
Physician's Office visit to confirm pregnancy	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	100%	85%, After Deductible	60%, After Deductible
Physician's Office visits in addition to the global maternity fee	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Laboratory, Radiology Services and or Advance Radiological Imaging	100%	85%, After Deductible	60%, After Deductible
Delivery Charges – Facility (Hospital, Birthing Center)	100%	85%, After Deductible	60%, After Deductible
Services of a Doula In home or facility up to 10 visits (pre and post-natal combined)	100%	Not Covered	Not Covered
Termination of Pregnancy			
Medically Necessary	100%	85%, After Deductible	60%, After Deductible
Elective	Not covered	Not covered	Not covered

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
<p>Infertility Expenses – Basic</p> <p>Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>100%, No Deductible, \$25 Copay</p> <p>85%, After Deductible</p> <p>85%, After Deductible</p> <p>85%, After Deductible</p>	<p>60%, No Deductible</p> <p>60%, After Deductible</p> <p>60%, After Deductible</p> <p>60%, After Deductible</p>
<p>Family Planning/Contraception Management</p> <p>See benefit description for specific coverages</p> <p>For Women</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p> <p>For Men</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>100% not subject to Plan Deductible or Copayments</p> <p>100% not subject to Plan Deductible or Copayments</p> <p>100% not subject to Plan Deductible or Copayments</p> <p>100% not subject to Plan Deductible or Copayments</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>100% not subject to Plan Deductible or Copayments</p> <p>100% not subject to Plan Deductible or Copayments</p> <p>100% not subject to Plan Deductible or Copayments</p> <p>100% not subject to Plan Deductible or Copayments</p> <p>100%, No Deductible, \$25 Copay</p> <p>85%, After Deductible</p> <p>85%, After Deductible</p> <p>85%, After Deductible</p>	<p>60%, No Deductible</p> <p>60%, No Deductible</p> <p>60%, No Deductible</p> <p>60%, No Deductible</p> <p>60%, No Deductible</p> <p>60%, No Deductible</p> <p>60%, After Deductible</p> <p>60%, After Deductible</p> <p>60%, After Deductible</p>

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
<p>Obesity/Bariatric Surgery</p> <p>Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese. Pre-authorization is required</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>100%, No Deductible, \$25 Copay</p> <p>85%, After Deductible</p> <p>85%, After Deductible</p> <p>85%, After Deductible</p>	<p>60%, No Deductible</p> <p>60%, After Deductible</p> <p>60%, After Deductible</p> <p>60%, After Deductible</p>
<p>Organ Transplant Services</p> <p>Includes all medically appropriate, non-Experimental transplants. Pre-authorization is required</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Physician's Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100% of Reasonable Expenses</p>	<p>100%, No Deductible, \$25 Copay</p> <p>85%, After Deductible</p> <p>85%, After Deductible</p> <p>100% of Reasonable Expenses after Plan Deductible</p>	<p>60%, No Deductible</p> <p>60%, After Deductible</p> <p>60%, After Deductible</p> <p>Not Covered</p>
<p>Nutritional Evaluation</p> <p>Calendar Year Maximum of 3 visit limit. Limit does not apply to treatment of diabetes or for services due to a mental health or substance abuse diagnosis.</p> <p>Physician's Office Visit</p>	<p>100%</p>	<p>100%, No Deductible, \$25 Copay</p>	<p>60%, No Deductible</p>
<p>Nutritional Formulas</p>	<p>100%</p>	<p>85%, After Deductible</p>	<p>60%, After Deductible</p>
<p>Acupuncture</p> <p>Physician's office visit</p>	<p>100%</p>	<p>100%, No Deductible, \$25 Copay</p>	<p>60%, No Deductible</p>

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Chiropractic Care/Spinal Manipulations Physician's office visit Calendar Year Maximum of 50 visit limit.	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Telehealth	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Limited Benefits – please see the benefit description for limitation on Dental Services due to an Injury Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	100% 100% 100% 100%	100%, No Deductible, \$25 Copay 85%, After Deductible 85%, After Deductible 85%, After Deductible	60%, No Deductible 60%, After Deductible 60%, After Deductible 60%, After Deductible
TMJ Treatment	100%	85%, After Deductible	60%, After Deductible
Diabetic Equipment	100%	85%, After Deductible	60%, After Deductible
Durable Medical Equipment	100%	85%, After Deductible	60%, After Deductible
External Prosthetic Appliances	100%	85%, After Deductible	60%, After Deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Calendar Year Maximum of \$500	100%	85%, After Deductible	60%, After Deductible
Mental Health Inpatient Facility Outpatient (Includes Individual, Group and Intensive Outpatient)	100%	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Physician's Office Visit	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Outpatient Facility	100%	85%, After Deductible	60%, After Deductible
Psycho-Educational Testing	100%	85%, After Deductible	60%, After Deductible
Substance Abuse Health			
Inpatient Facility	100%	85%, After Deductible	60%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Outpatient Facility	100%	85%, After Deductible	60%, After Deductible
Hearing Benefit			
One Examination per 12 month period	100%	100%, No Deductible, \$25 Copay	60%, No Deductible
Hearing Aid Benefit			
Up to \$1,000 per hearing aid unit necessary for each hearing impaired ear every 36 months	100%	85%, After Deductible	60%, After Deductible
Home Health Care Services			
Calendar Year Maximum of 120 visit limit.	100%	85%, After Deductible	60%, After Deductible
Private Duty Nursing			
Calendar Year Maximum of 120 visit limit.	100%	85%, After Deductible	60%, After Deductible
Hospice Care Services	100%	85%, After Deductible	60%, After Deductible
Infusion Therapy			
Outpatient Facility	100%	85%, After Deductible	60%, After Deductible
Physician's Services	100%	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
<p>Short Term Rehabilitative Therapy</p> <p>Calendar Year Maximum of 30 visit limit for all therapies combined.</p> <p>Physician's Office Visit</p> <p>Outpatient Hospital Facility</p> <p>Note: The Short Term Rehabilitative Therapy maximum does not apply to the treatment of autism.</p>	<p>100%</p> <p>100%</p>	<p>100%, No Deductible, \$25 Copay</p> <p>85%, After Deductible</p>	<p>60%, No Deductible</p> <p>60%, After Deductible</p>

Prescription Drugs - Schedule of Benefits

Prescription Drugs Purchased Outside of the United States		
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply		
Tier 1 Prescription Drugs – Generic	\$10 Copayment per Prescription or refill. Deductible does not apply.	
Tier 2 Prescription Drugs – Preferred Brand	\$10 Copayment per Prescription or refill. Deductible does not apply.	
Tier 3 Prescription Drugs – non Preferred Brand	\$10 Copayment per Prescription or refill. Deductible does not apply.	
Mail Order Prescription Drugs using the Insurer’s mail order Prescription Drug vendor – Copayments based on a three (3) month supply		
Tier 1 Prescription Drugs – Generic	\$30 Copayment per Prescription or refill. Deductible does not apply.	
Tier 2 Prescription Drugs – Preferred Brand	\$30 Copayment per Prescription or refill. Deductible does not apply.	
Tier 3 Prescription Drugs – non Preferred Brand	\$30 Copayment per Prescription or refill. Deductible does not apply.	
Prescription Drugs Purchased Inside of the United States		
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply		
	Participating Retail Pharmacy	Non-Participating Retail Pharmacy
Tier 1 Prescription Drugs – Generic	\$10 Copayment per Prescription or refill. Deductible does not apply.	\$10 Copayment per Prescription or refill. Deductible does not apply.
Tier 2 Prescription Drugs – Preferred Brand	\$30 Copayment per Prescription or refill. Deductible does not apply.	\$30 Copayment per Prescription or refill. Deductible does not apply.
Tier 3 Prescription Drugs – non Preferred Brand	30% Copayment per Prescription or refill. Deductible does not apply. The Maximum Copayment per 1 month supply is \$150.	30% Copayment per Prescription or refill. Deductible does not apply. The Maximum Copayment per 1 month supply is \$150.
Mail Order Prescription Drugs using the Insurer’s mail order Prescription Drug vendor – Copayments based on a three (3) month supply		
	Participating Provider Mail Order Pharmacy	Non-Participating Mail Order Pharmacy
Tier 1 Prescription Drugs – Generic	\$30 Copayment per Prescription or refill. Deductible does not apply.	Not Covered
Tier 2 Prescription Drugs – Preferred Brand	\$90 Copayment per Prescription or refill. Deductible does not apply.	Not Covered
Tier 3 Prescription Drugs – non Preferred Brand	30% Copayment per Prescription or refill. Deductible does not apply. The Maximum Copayment per 3 month supply is \$450.	Not Covered

Dental Services Rider

<ul style="list-style-type: none"> Calendar Year Maximum Combined Benefit for Diagnostic and Preventive Service, Basic Services and Major Services 	\$3,000
<ul style="list-style-type: none"> Orthodontic Lifetime Maximum <i>Limited to Covered Persons under age 19</i> 	\$1,500
<ul style="list-style-type: none"> Per Person Calendar Year Dental Deductible <i>Not applicable to Diagnostic and Preventive Services</i> <ul style="list-style-type: none"> Family Maximum 	\$0
<ul style="list-style-type: none"> Per Person Calendar Year Orthodontic Deductible 	\$0
<ul style="list-style-type: none"> Diagnostic and Preventive Services 	0%
<ul style="list-style-type: none"> Basic Services 	20%
<ul style="list-style-type: none"> Major Services 	20%
<ul style="list-style-type: none"> Orthodontic Services <i>Limited to Covered Persons under age 19</i> 	50%

Vision Care Rider

Examinations One Eye Exam every 12 Consecutive months	100% coverage, not subject to any Deductible
Lenses & Frames One pair of glasses or contact lenses per 12 Consecutive months	100% coverage, not subject to any Deductible, up to a Maximum Benefit of \$250

Medical Assistance Rider

EMERGENCY MEDICAL EVACUATION	Maximum Benefit up to \$250,000
REPATRIATION OF MORTAL REMAINS	Maximum Benefit up to \$25,000
EMERGENCY FAMILY TRAVEL ARRANGEMENTS	Maximum Benefit up to \$2,500