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
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.			
Calendar Year Medical Deductible			
Individual	$350	$350	$700
Family Maximum	2 times the individual Deductible	2 times the individual Deductible	2 times the individual Deductible
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.			
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
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%.			
Physician's Services			
Physician's Office Visit - Primary Care Physician	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Office Visit – Specialist	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Surgery Performed In the Physician's Office	100%, After Deductible	85%, After Deductible	60%, After Deductible
Second Opinion Consultations (provided on a voluntary basis)	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Allergy Treatment/Injections	100%, No Deductible	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%, No Deductible	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%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Visits/Consultations	100%, After Deductible	85%, After Deductible	60%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%, After Deductible	85%, After Deductible	60%, After Deductible
Inpatient Services at Other Heath Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum of 120 day limit.	100%, After Deductible	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	100%, After Deductible	85%, After Deductible	60%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%, After Deductible	85%, After Deductible	60%, After Deductible
Emergency and Urgent Care Services			If You have a true Emergency Medical Condition, the benefits will be paid at the U.S. Participating Provider Rate
Hospital Emergency Room	100%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Professional Services (radiology, pathology and ER Physician)	100%, After Deductible	85%, After Deductible	60%, After Deductible
Urgent Care Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	100%, After Deductible	85%, After Deductible	60%, After Deductible
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	100%, After Deductible	85%, After Deductible	60%, After Deductible
Ambulance	100%, After Deductible	85%, After Deductible	60%, After Deductible
Laboratory and Radiology Services (includes pre-admission testing)			
Inpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Independent X-ray and/or Lab Facility	100%, After Deductible	85%, 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%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Independent Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Maternity Care/Obstetrical Services			
Physician's Office visit to confirm pregnancy	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	100%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Office visits in addition to the global maternity fee	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Laboratory, Radiology Services and or Advance Radiological Imaging	100%, After Deductible	85%, After Deductible	60%, After Deductible
Delivery Charges – Facility (Hospital, Birthing Center)	100%, After Deductible	85%, After Deductible	60%, After Deductible
Services of a Doula In home or facility up to 10 visits (pre and post-natal combined	100%, After Deductible	Not Covered	Not Covered
Termination of Pregnancy			
Medically Necessary	100%, After Deductible	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
Infertility Expenses – Basic Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.			
Physician's Office Visit	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Inpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	100%, After Deductible	85%, After Deductible	60%, After Deductible
Family Planning/Contraception Management See benefit description for specific coverages			
For Women			
Physician's Office Visit	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Inpatient Facility	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Outpatient Facility	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Physician's Services	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
For Men			
Physician's Office Visit	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Inpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	100%, After Deductible	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Obesity/Bariatric Surgery Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese. Pre-authorization is required			
Physician's Office Visit	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Inpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	100%, After Deductible	85%, After Deductible	60%, After Deductible
Organ Transplant Services Includes all medically appropriate, non-Experimental transplants. Pre-authorization is required			
Physician's Office Visit	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Inpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	100%, After Deductible	85%, After Deductible	60%, After Deductible
Lifetime Travel Maximum: $10,000 per transplant	100% of Reasonable Expenses after Plan Deductible	100% of Reasonable Expenses after Plan Deductible	Not Covered
Nutritional Evaluation 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.			
Physician's Office Visit	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Nutritional Formulas	100%, After Deductible	85%, After Deductible	60%, After Deductible
Acupuncture Physician's office visit	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible

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%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Telehealth	100%, No Deductible	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	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Inpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	100%, After Deductible	85%, After Deductible	60%, After Deductible
TMJ Treatment	100%, After Deductible	85%, After Deductible	60%, After Deductible
Diabetic Equipment	100%, After Deductible	85%, After Deductible	60%, After Deductible
Durable Medical Equipment	100%, After Deductible	85%, After Deductible	60%, After Deductible
External Prosthetic Appliances	100%, After Deductible	85%, After Deductible	60%, After Deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Calendar Year Maximum of $500	100%, After Deductible	85%, After Deductible	60%, After Deductible
Mental Health Inpatient Facility Outpatient (Includes Individual, Group and Intensive Outpatient)	100%, After Deductible	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Physician's Office Visit	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Psycho-Educational Testing	100%, After Deductible	85%, After Deductible	60%, After Deductible
Substance Abuse Health			
Inpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	100%, No Deductible	100%, No Deductible, $25 Copay	60%, No Deductible
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Hearing Benefit One Examination per 12 month period	100%, No Deductible	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%, After Deductible	85%, After Deductible	60%, After Deductible
Home Health Care Services Calendar Year Maximum of 120 visit limit.	100%, After Deductible	85%, After Deductible	60%, After Deductible
Private Duty Nursing Calendar Year Maximum of 120 visit limit.	100%, After Deductible	85%, After Deductible	60%, After Deductible
Hospice Care Services	100%, After Deductible	85%, After Deductible	60%, After Deductible
Infusion Therapy			
Outpatient Facility	100%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	100%, After Deductible	85%, After Deductible	60%, After Deductible

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

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

• Calendar Year Maximum Combined Benefit for Diagnostic and Preventive Service, Basic Services and Major Services	$3,000
• Orthodontic Lifetime Maximum *Limited to Covered Persons under age 19*	$1,500
• Per Person Calendar Year Dental Deductible *Not applicable to Diagnostic and Preventive Services*	$0
• Family Maximum	$0
• Per Person Calendar Year Orthodontic Deductible	$0
• Diagnostic and Preventive Services	0%
• Basic Services	20%
• Major Services	20%
• Orthodontic Services *Limited to Covered Persons under age 19*	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