Medical Plan (BCBS Global GeoBlue)

Expatriate Health Plan
00109576

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	90%	80%	60% of the Allowed Amount
Policy Year Medical Deductible			
Individual	$0	$1,000	$1,000
Family Maximum	$0	3 times the individual Deductible	3 times the individual Deductible
Out-of-Pocket Maximum			
Individual	$1,000	$3,000	$9,000
Family Maximum	2 times the individual Out-of-Pocket Maximum	3 times the individual Out-of-Pocket Maximum	3 times the individual Out-of-Pocket Maximum
The following expenses contribute to the Out-of-Pocket Maximum: Coinsurance			
Accumulation of Plan Deductibles and Out-of-Pocket Maximums Deductibles and Out-of-Pocket Maximums will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International. All other Plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.			
Preventive Care			
Routine Preventive Care – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments
Immunizations – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments
Physician's Services			
Physician's Office Visit - Primary Care Physician	90%	80%, After Deductible	60%, After Deductible
Office Visit – Specialist	90%	80%, After Deductible	60%, After Deductible
Travel Immunizations	100%		

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Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Acupuncture or Acupressure Policy Year Maximum of 20 visit limit.	90%	80%, After Deductible	60%, After Deductible
Chiropractic Care/Spinal Manipulations	90%	80%, After Deductible	60%, After Deductible
Alternate Therapies and Non-Traditional Medical Services	90%	Not Covered	Not Covered
Habilitative and Rehabilitative Therapy Policy Year Maximum of 60 visit limit for all therapies combined	90%	80%, After Deductible	60%, After Deductible
Hearing Benefit One Examination per 24-month period	90%	80%, After Deductible	60%, After Deductible
Hearing Aid Benefit Up to $1,000 per hearing aid unit necessary for each hearing-impaired ear every 36 months **State specific limitations or mandates may apply.**	Covered Same as any other Illness	Covered Same as any other Illness	Covered Same as any other Illness
Inpatient Hospital – Facility/Professional Charges	90%	80%, After Deductible	60%, After Deductible
Emergency and Urgent Care Services		If true emergency, the benefit will be paid at the U.S. Participating Provider Rate.	
Hospital Emergency Room	90%	80%, After Deductible	60%, After Deductible
Urgent Care Facility	90%	80%, After Deductible	60%, After Deductible
Ambulance	90%	100%, No Deductible	100%, No Deductible
Laboratory and Radiology Services	Covered Same as any other medical condition	Covered Same as any other medical condition	Covered Same as any other medical condition
Maternity Care/Obstetrical Services	Covered Same as any other medical condition	Covered Same as any other medical condition	Covered Same as any other medical condition
Services of a Doula In home or facility up to 10 visits (pre and post-natal combined)	Covered Same as any other medical condition	Not Covered	Not Covered

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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.	Covered Same as any other medical condition	Covered Same as any other medical condition	Covered Same as any other medical condition
Infertility Expenses – Comprehensive State specific mandates may apply	Covered Same as any other medical condition	Covered Same as any other medical condition	Covered Same as any other medical condition

Prescription Drugs – Retail and Mail Order

Copayments based on a one (1) month supply

	Outside of the United States	Inside of the United States	
		Participating Retail Pharmacy	Non Participating Retail Pharmacy
Tier 1 Prescription Drugs – Generic	10% Copayment per Prescription	$20 Copayment per Prescription or refill. Deductible does not apply	40% Copayment per Prescription or refill, after Plan Deductible
Tier 2 Prescription Drugs – Preferred Brand	10% Copayment per Prescription	$40 Copayment per Prescription or refill. Deductible does not apply	40% Copayment per Prescription or refill, after Plan Deductible
Tier 3 Prescription Drugs – non Preferred Brand	10% Copayment per Prescription	$60 Copayment per Prescription or refill. Deductible does not apply.	40% Copayment per Prescription or refill, after Plan Deductible

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Benefit Summary

Benefits common to all plans: **(Subject to Maximums, Coinsurance, and Deductibles in Overview Matrix)**

- Hospice Care Services – Up to $10,000 per policy year
- Ambulatory Surgical Services
- Interruption of Pregnancy
- Obesity/Bariatric Surgery
- Organ Transplant Services
- Mental Health and Substance Use Disorder Treatment
- Autism Treatment including ABA Therapy – Up to $37,455.43 maximum per calendar year to age 21
- Gender Identity Disorder Treatment
- Nutritional Formulas
- TMJ Treatment – Up to $1,000 per lifetime
- Diabetic Equipment
- Durable Medical Equipment
- External Prosthetic Appliances
- Infusion Therapy
- Advanced Radiological Imaging
- Dental Services due to an Injury and Oral and Maxillofacial Treatment
- Inpatient Services at Other Heath Care Facilities – daily limitations apply
- Home Health Care Services - daily limitations apply
- Private Duty Nursing - daily limitations apply

Medical Assistance Services	
Emergency Medical Evacuation	$250,000
Repatriation of Mortal Remains	$25,000
Emergency Family Travel Arrangements	Maximum Benefit up to $10,000

Vision Benefits	
Examinations One Eye Exam every 24 months	100% coverage, not subject to any Deductible
Lenses & Frames One pair of glasses or contact lenses per 24 Month	100% coverage, not subject to any Deductible, up to a Maximum Benefit of $250

Dental Benefits	
Policy Year Maximum Combined Benefit for Diagnostic and Preventive Service, Basic Services and Major Services	$1,500
Orthodontic Lifetime Maximum *Limited to Covered Person's under age* 19	$1,000
Per Person Policy Year Dental Deductible *Not applicable to Diagnostic and Preventive Services* Family Maximum	$25 $75
Diagnostic and Preventive Services	0% member co-insurance
Basic Services	20% member co-insurance
Major Services	50% member co-insurance
Orthodontic Services Limited to Covered Person's under age 19	50% member co-insurance

DISCLAIMER: This is a proposed summary of benefits and is not a part of your Policy. The entire plan, including benefits, exclusions, limitations and other important coverage provisions are shown in the Certificate of Coverage. The benefits or coverages shown in this summary may be changed to comply with state and federal requirements.

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