



**BlueCross
BlueShield®**
Global

Welcome to Blue Cross Blue Shield Global®

Simplifying the international healthcare experience through leading networks, brand strength and personalized service

CU HEALTH PLAN

Brought to you by the international
healthcare experts at

GeoBlue®

WELCOME TO YOUR COMPANY HEALTH PLAN

Healthcare providers know and trust the Blue Cross Blue Shield name in the U.S. and Bupa Global overseas. The power of those two brands gives members of Blue Cross Blue Shield Global access to one of the largest care networks in the world. That, coupled with high-touch services from GeoBlue creates a simplified, personalized international healthcare experience.

INTRODUCTION TO YOUR HEALTH PLAN



Important plan information and health tools

ACCESSING CARE



How to receive care throughout your journey

DEDICATED WELLNESS SUPPORT



Health and wellbeing services

SELF-SERVICE TOOLS



Convenient tools available on the Member Hub and mobile app

SUBMITTING A CLAIM



File a claim for reimbursement

This pamphlet contains a brief summary of the features and benefits for insured participants covered under your company health insurance. This is not a contract of insurance. Coverage is provided under an insurance policy under which your company is a participating company. The policy is underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois (policy form 54.1201/54.1205/54.1215). Complete information on the insurance is contained in the Certificate of Coverage which is on file with the company and is made available to all insured participants. If there is a difference between this program description and the certificate wording, the certificate controls.



INTRODUCTION TO YOUR HEALTH PLAN

IMPORTANT PLAN INFORMATION AND HEALTH TOOLS



Register for the GeoBlue Member Hub and mobile app to access important plan information

- Submit and track your claims
- Obtain electronic ID card(s)
- Locate providers worldwide through our global provider directory
- Access global health and safety tools including medical translations, drug equivalents and news and safety information

To register, visit www.geo-blue.com or download the GeoBlue app from the Apple or Google Play app stores. After you register you can use your log in information for both the website and app.

Two of the strongest brands in healthcare, placed right in your pocket

As a Blue Cross Blue Shield Global plan participant, you will receive two ID cards. Your Blue Cross Blue Shield Global ID card should be presented when accessing care within the U.S. and your Bupa Global ID card should be presented when accessing care outside the U.S.*

It is important to have your ID card(s) available when receiving healthcare services. Your cards can be accessed from multiple sources:

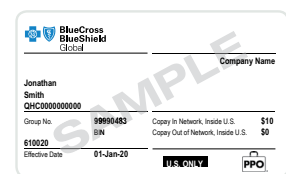
- Hardcopy ID cards will be mailed to you
- You can obtain an electronic version of your ID card on the Member Hub or mobile app
- You can request replacement ID cards through the Member Hub and mobile app. You can also contact customer service for assistance in requesting replacement ID card(s)

When you receive your ID cards, please check the information for accuracy. Please contact customer service if you find any errors.

Your ID card for use outside the U.S.



Your ID card for use within the U.S.



ID card images for illustration purposes only

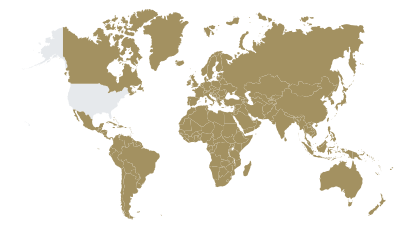
Need help?

**WE'RE AVAILABLE
24/7/365 TO ASSIST**



**Call the number on the
back of your ID card.**





ACCESSING CARE

FIND HEALTHCARE PROFESSIONALS OUTSIDE THE U.S. AND SCHEDULE APPOINTMENTS



Find a Provider

By using your Bupa Global ID card, you have access to one of the largest direct settlement networks outside the U.S.* Simply present your Bupa Global ID card at the point of treatment.

To find a nearby doctor or facility, visit the **“Find Doctors and Hospitals Outside the U.S.”** section of the Member Hub on www.geo-blue.com or select **“Provider Finder”** in the app.

Outside of the U.S., you are free to see any physician you choose without a reduction of benefits. If you see a provider outside of the preferred provider** network, you may have to pay out of pocket for treatment and submit a claim for reimbursement.



Schedule an Appointment

To schedule an appointment, choose a provider or hospital through the Member Hub or mobile app. Contact them directly using the information in their profile. Most eligible treatment is settled directly with the physician or facility behind the scenes. Preferred providers have tools at the point of service to confirm your eligibility and benefits and facilitate direct payment. Direct settlement for outpatient (office-based) services is always at the option of the preferred provider.



YOUR ID CARD FOR USE OUTSIDE THE U.S.

For illustration purposes only



FIND PROVIDER



PRESENT ID CARD



GET CARE

Global TeleMD



We know how important it is to get the healthcare you need, when you need it.

In addition to the worldwide network of healthcare professionals available through your health plan, we've teamed up with Teladoc Health to bring you Global TeleMD, a new smartphone app at no additional cost, that provides unlimited, 24/7/365 access to doctor consultations by telephone or video. Doctors are available worldwide. Prescriptions may also be provided, as appropriate (subject to local regulations).

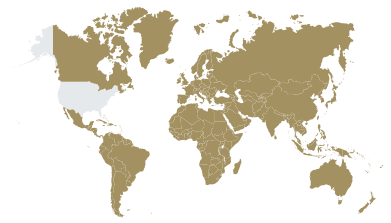
*You are required to pay any applicable copayments, coinsurance or deductibles at the time of service.

**Hospitals/facilities with this designation have agreed to accept direct settlement for inpatient services and may at their discretion accept direct settlement for outpatient services. Physicians and other non-facility providers will accept direct settlement in most instances for their services.

Medical Emergency?

In the event of a medical emergency you should go to the nearest physician or hospital immediately and present your ID card. **We're available 24/7/365** if you have any questions about your benefits or need assistance.





ACCESSING CARE

PRESCRIPTION MEDICATIONS, ASSISTANCE AND OTHER SERVICES OUTSIDE THE U.S.

Dental and Vision Services*

You are free to see any dental or vision care provider you choose. Check with your provider's office to see if they are willing to bill us directly. If so, they should send the claim form and invoice to:

GeoBlue, Attn: Claims Department, P.O. Box 1748, Southeastern, PA 19399-1748, USA.
Email: claims@geo-blue.com
Fax: +1-610-482-9623

If direct settlement is not an option, provide payment directly to the provider's office and then submit a claim for reimbursement.

Prescription Benefits

Prescription benefit coverage provided under the plan includes benefits for both retail pharmacies and a mail order prescription drug program. Use the international mail order program to fill your prescription medication(s), or pay for your prescription up front at a pharmacy and submit a claim for reimbursement. Not all members have access to all prescription drug services. Review your Certificate of Coverage for detailed benefit information. To learn more and download the appropriate forms, visit "**Prescription Benefits**" in the "**Coverage & Benefits**" section of the Member Hub at www.geo-blue.com.

Informed Choice Consultation

When unexpected medical complications affect our lives, sometimes a second opinion may confirm a diagnosis or treatment recommendation. Members can submit an Informed Choice request for additional medical advice from any of our local medical resources around the world.

Visit the "**Informed Choice**" section of the Member Hub at www.geo-blue.com.

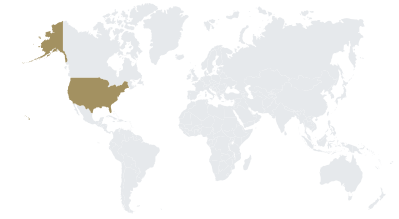
Chronic Care and Maternity Support

Let us arrange the best local resources to help manage cancer, heart disease, sports injuries, behavioral conditions and maternity.

Contact us 24/7/365 via the telephone number on the back of your ID card.

**Not all plans include benefits for dental and vision services. Please check your Certificate of Coverage which is available on the Member Hub.*





ACCESSING CARE

FIND HEALTHCARE PROFESSIONALS WITHIN THE U.S. AND SCHEDULE APPOINTMENTS



Accessing Care

You have access to the leading Blue Cross Blue Shield network within the U.S., Puerto Rico and U.S. Virgin Islands. To find a doctor or facility, visit the **“Find Doctors and Hospitals Inside the U.S.”** section in the Member Hub on www.geo-blue.com or select **“Provider Finder”** in the mobile app.

For assistance contact us 24/7/365 via the telephone number on the back of your ID card.



Scheduling an Appointment with a Blue Cross Blue Shield Provider

Call the provider to confirm they are in network and schedule your appointment. You will need to show the provider your ID card at the time of service.



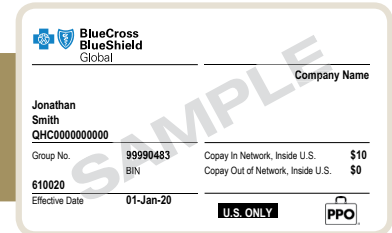
Receiving Medical Services from an Out-of-Network Provider

This typically results in a higher coinsurance and may result in additional costs to you. If you receive care from an out-of-network provider, you may need to pay out of pocket and submit a claim for reimbursement. Click **“How to File Claims”** in the Member Hub on www.geo-blue.com to download the appropriate claim form.

Submit claims electronically using the mobile app or the **“File an eClaim”** link on the Member Hub.

YOUR ID CARD FOR USE WITHIN THE U.S.

For illustration purposes only



Pre-Authorization

Pre-authorization is the process of determining in advance whether a procedure, treatment or service will be covered under your healthcare plan. It also helps ensure you get the right care in the right setting – potentially saving you from costly and unnecessary services.

For example, innovations in healthcare enable doctors to provide services that were once provided exclusively in an inpatient setting, in many different settings, such as an outpatient department of a hospital or a doctor’s office.

WHO IS RESPONSIBLE FOR GETTING THE PRE-AUTHORIZATION?

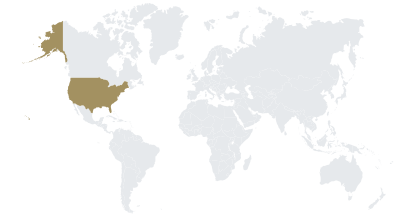
In most cases, when you seek treatment from an in-network provider, they will initiate the pre-authorization process. If you see an out-of-network provider, you are responsible for initiating the pre-authorization process. For more information regarding pre-authorization, please see the Certification Requirements and Pre-Authorization section in your Certificate of Coverage.

To request pre-authorization, please contact us at 1-800-952-3404.

24/7/365 multilingual support when you want it, help when you need it

CONTACT US ANYTIME FOR:

- Help locating providers
- Questions about accessing care or health concerns
- Medical evacuation/repatriation coordination
- Pre-departure assistance



ACCESSING CARE

PRESCRIPTION MEDICATIONS, ASSISTANCE AND OTHER SERVICES WITHIN THE U.S.

Prescription Benefits

Present your ID card at any participating pharmacy and you will be charged in accordance with your plan benefits.*

Dental and Vision Services**

You are free to see any dental or vision care provider you choose. Check with your provider's office to see if they are willing to bill us directly. If so, they should send the claim form and invoice to:

GeoBlue, Attn: Claims Department, P.O. Box 1748, Southeastern, PA 19399-1748, USA.
Email: claims@geo-blue.com
Fax: +1-610-482-9623

If direct settlement is not an option, provide payment directly to the provider's office and then submit a claim for reimbursement.

Maternity Management

The Baby Beginnings® program can help you manage your health when you're planning, expecting and after delivery with the support of experienced nurses. You'll have access to valuable wellness, nutrition and lifestyle resources designed to help you make wise health decisions before you become pregnant. Then take advantage of educational tools and personalized resources to manage your pregnancy and when you need support after the baby is born.***

For more information, please call 1-888-206-1315. If you are already enrolled in the program, you can also text BABY to 511411.

Important Terms

- **Coinsurance:** The percentage of the cost you are responsible for.
- **Coinsurance Maximum:** The maximum amount of coinsurance a member pays during the policy year for covered expenses. Limitations may apply.
- **Copay or Copayment:** The specific dollar amount you will pay at the time of service.
- **Deductible:** An amount you are responsible to pay for eligible expenses before the plan begins to pay.
- **Explanation of Benefits (EOB):** An EOB is not a bill, but a summary of how your claims were processed and what you may owe. Your healthcare professional may bill you directly for the remainder of what you owe.
- **Out-of-Network Provider:** A medical provider who is not contracted with Blue Cross Blue Shield companies. This typically results in a higher coinsurance and may result in additional costs to you.
- **Out-of-Pocket Maximum:** The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount.

See your Certificate of Coverage for more details.



*Certain limitations and exclusions apply to your coverage under this plan and may affect your coverage. Your Certificate of Coverage is on file with your company and in the Member Hub on www.geo-blue.com.

**Not all plans include benefits for dental and vision services. Please check your Certificate of Coverage which is available on the Member Hub.

***Available until your baby is six weeks old.

Maternity management services are provided by AmeriHealth Administrators, Inc. on behalf of GeoBlue and are available inside the U.S. Services are provided by AmeriHealth Administrators, Inc., an independent company that is not affiliated with GeoBlue and does not provide Blue Cross or Blue Shield products or services. AmeriHealth Administrators, Inc. is solely responsible for case management services by providers. The evaluation and efficacy of any service delivered by a provider lies solely with the participant, spouse, dependent or other authorized party who inquires on behalf of the participant and AmeriHealth Administrators. GeoBlue shall have no responsibility or liability whatsoever for any aspect of the provider/participant relationship or the services rendered to a participant by a provider.



DEDICATED WELLNESS SUPPORT

HEALTH AND WELLBEING SERVICES

We offer a variety of emotional, practical and physical support services for you and your dependents, helping to make transitions more comfortable and assignments more successful.



Emotional Support

- ✓ 24/7/365 clinical intake, message and referral service from triage to crisis intervention
- ✓ Short-term, solution-focused telephonic counseling sessions
- ✓ Aware program for those in need of a mindfulness-based stress reduction strategy
- ✓ Virtual group counseling for participants with similar presenting issues



Practical Support

- ✓ Work-life consultation and referrals for a nearly limitless range of topics including childcare, elder care and daily living
- ✓ Unlimited telephonic financial assistance from financial professionals
- ✓ Telephonic or in-person legal assistance and consultation with attorneys



Physical Support

- ✓ Wellness coaching and support for wellness initiatives, including weight loss, fitness, nutrition, stress management and overall lifestyle improvement
- ✓ Health risk assessment to obtain and assess individual and aggregate health data

Employee Assistance Program (EAP)

For confidential assistance with any work, life, personal or family issue, you can talk to professional counselors for in-the-moment support and referrals to local resources around the world.

AVAILABLE ANY DAY, ANY TIME. CONTACT:

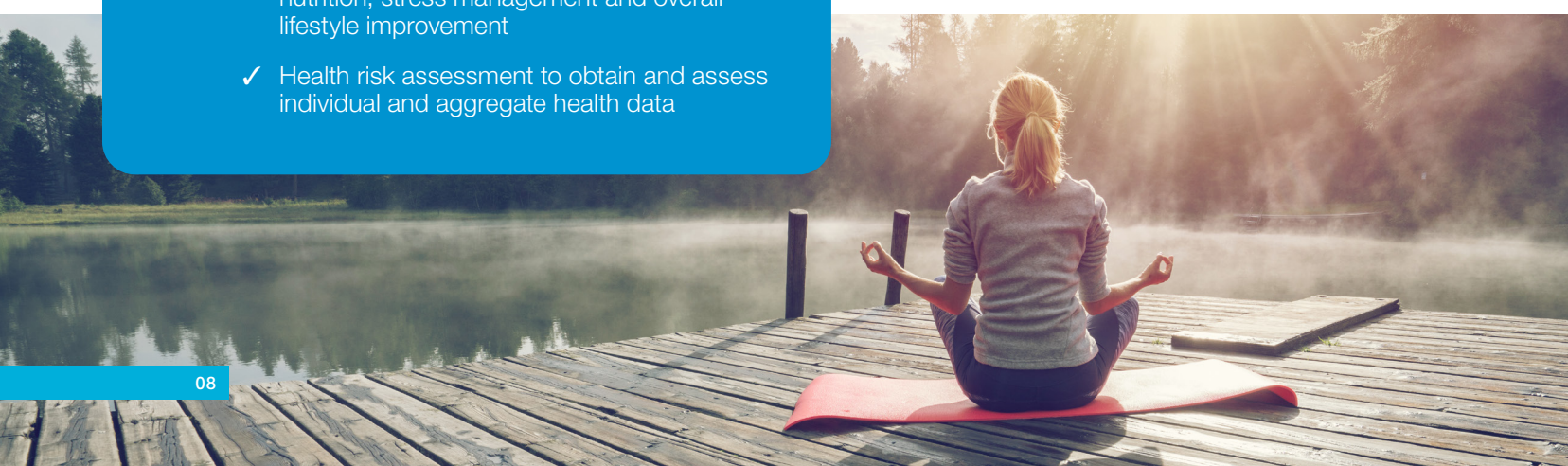
- Inside the U.S.: **1-877-249-4765**
- Outside the U.S.: **+44-208-987-6228**
- **support@worldwideassist.co.uk**

Wellness Services

Set your baseline by taking the Health Assessment and then work to improve your wellness via a one-on-one telephone relationship with a Wellness Coach or by using one of the online programs to address issues related to fitness, weight, smoking and stress.

TO CONTACT A WELLNESS COACH:

- Inside the U.S.: **1-877-249-4752**
- Outside the U.S.: **+44-208-987-6229**
- **contactacoach@wellness-assist.com**





SELF-SERVICE TOOLS

WHY USE THE GEOBLUE MEMBER HUB OR MOBILE APP?



Our digital tools put access to global healthcare right in your hands! Our hyper-personal interfaces provide relevant information based on your profile. There is a wide range of information available to you on the Member Hub, including:



Claim Submission and Status

Submit and track the status of your claims.



ID Card(s)

Obtain an electronic copy of your ID card(s) and request replacements.



Provider Directory

You can review profiles of preferred doctors and hospitals to find the best match, view their contact details and locate the office.



Medical Term Translations

Translation tool for common healthcare terms and phrases.



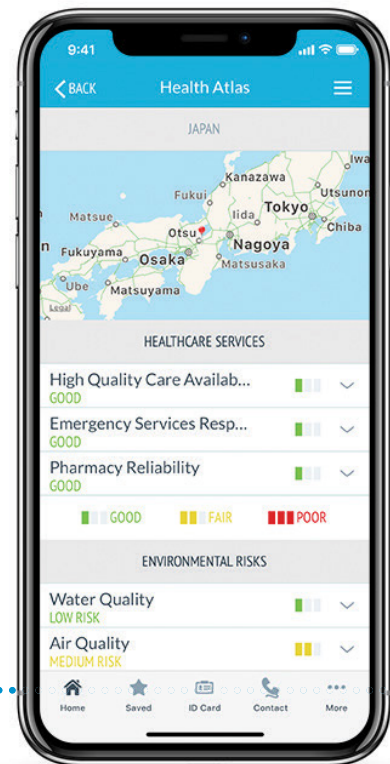
Medicine Equivalent Tool

Find country-specific equivalents for prescription and over-the-counter medications.



News and Safety Information

Receive push notifications and alerts detailing the latest security and health issues based on your location. You can also view country or city profiles on crime, terrorism and natural disasters.



Download the app today!

Download the app and log in using your username and password from www.geo-blue.com or register as a new user through the app using information from your ID card.





CLAIM SUBMISSION

HOW TO CLAIM

Whether you choose a preferred provider that we pay directly or pay up front for services and submit a claim for reimbursement, the claim process is quick and easy. Direct settlement is easier for us to arrange if you confirm your treatment with us first, or if you use a preferred hospital or healthcare professional.

Direct Settlement

Direct settlement is where we pay the provider directly, making things easier for you.

OR

Pay and Claim

You pay up front for services and then submit a claim to us for reimbursement.

1

You should present your ID card when you receive treatment.

After you visit your treating provider, be sure to fill out a claim form in its entirety. A claim form can be found on the Member Hub.

2

We send the treating provider a verification statement.
We will also send a copy to you upon request.

Once you have received medical services and paid the treating provider, you should complete all sections of the claim form, include the original bills and receipts and send the claim to us.

3

The treating provider will ask you to review or complete paperwork, as appropriate. If you have coinsurance or a remaining deductible* on any benefit, you will need to pay this directly to the treating provider. The treating provider will then send your claim to us.

You can submit your claim online via the Member Hub or mobile app, or mail/fax it to us.

4

We pay the treating provider directly.

We reimburse you. If you have an annual deductible or a coinsurance applied to your claim we will reimburse you the cost of the claim minus the percentage of the coinsurance or the amount of the remaining annual deductible.

5

We will send you an EOB*.
When we settle your claim, your benefits are paid in line with the limits shown in your Certificate of Coverage.

**Please see definitions on page 7.*

**IF YOU NEED ASSISTANCE WITH A CLAIM,
WE'RE AVAILABLE TO HELP 24/7/365.**



**Call the number on the
back of your ID card.**



CLAIM SUBMISSION

IF YOU NEED TO SUBMIT A CLAIM FOR REIMBURSEMENT, YOU HAVE THE FOLLOWING OPTIONS:



eClaims

We recommend submitting your claims through the Member Hub or mobile app which are the quickest and most convenient ways. Your eClaims are saved in the claims section of the Member Hub. Choose Claims in the GeoBlue app or visit the **“File an eClaim”** section of the Member Hub.

Email and Fax

If you prefer to submit a claim via email or fax, a printable claim form and detailed instructions are available on the Member Hub.

Visit the **“How to File Claims”** section of the Member Hub on www.geo-blue.com and click **“How do you file a claim with GeoBlue?”** to download the appropriate claim form.

Postal Mail

If you prefer to submit a claim via postal mail, a printable claim form and detailed instructions are available on the Member Hub on www.geo-blue.com.

Visit the **“How to File Claims”** section of the Member Hub on www.geo-blue.com and click **“How do you file a claim with GeoBlue?”** to download the appropriate claim form.

**Mail to: GeoBlue, Attn: Claims Department,
P.O. Box 1748, Southeastern, PA 19399-1748, USA.**

Follow these tips to speed up the claims reimbursement process:

- ✓ If you mail or fax your claim(s) make sure your claim form is filled out completely, and don't forget to sign it.
- ✓ Fill out a separate form for each doctor or office visit.
- ✓ Be sure to add a diagnosis or reason for treatment.
- ✓ Provide a detailed description and amount charged for each service.
- ✓ Clearly state how you'd like to be reimbursed.
- ✓ Make and keep handy copies of your bills, receipts and claim forms.



Missing information on the claim form or supporting documentation may delay your claim reimbursement.

Need to Check the Status of your Claim?

No problem! Simply choose **“Claims”** in the GeoBlue app or visit the **“Claims”** section of the Member Hub. If you are using the mobile app, you can elect to receive a push notification when your claim is processed. For more help, visit the **“Claims”** section of the Member Hub.



Overview of Benefits

Schedule of Benefits

Lifetime Maximum	Unlimited	Unlimited	Unlimited
The Percentage of Covered Expenses the Plan Pays	100%	100%	80% 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>			
Policy Year Medical Deductible			
Individual	\$350	\$350	\$500
Family Maximum	3 times the individual Deductible	3 times the individual Deductible	3 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	\$6,500	\$6,500	\$10,000
Family Maximum	2 times the individual Out-of-Pocket Maximum	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%, After Deductible	100%, No Deductible, \$30 Copay	80%, After Deductible
Office Visit – Specialist	100%, After Deductible	100%, No Deductible, \$40 Copay	80%, After Deductible
Surgery Performed In the Physician's Office	100%, After Deductible	100%, After Deductible	80%, After Deductible
Second Opinion Consultations (provided on a voluntary basis)	100%, After Deductible	100%, No Deductible, \$30 Copay	80%, After Deductible
Allergy Treatment/Injections	100%, After Deductible	100%, No Deductible, \$40 Copay	80%, After Deductible

Preventive Care			
Routine Preventive Care – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
Immunizations – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
Travel Immunizations			
Policy Year Maximum of \$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	80%, After 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	80%, After Deductible
Inpatient Hospital – Facility/Professional Charges			
Bed and Board Charges	100%, After Deductible	100%, After Deductible	80%, After Deductible
Physician's Visits/Consultations	100%, After Deductible	100%, After Deductible	80%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%, After Deductible	100%, After Deductible	80%, After Deductible
Inpatient Services at Other Health Care Facilities			
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities	100%, After Deductible	100%, After Deductible	80%, After Deductible
Policy Year Maximum of 120 day limit.			
Ambulatory Surgical Services			
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	100%, After Deductible	100%, After Deductible	80%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%, After Deductible	100%, After Deductible	80%, 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	100%, No Deductible Additional \$250 Copay per visit – waived if admitted	80%, After Deductible
	Outpatient Professional Services (radiology, pathology and ER Physician)	100%, After Deductible	100%, No Deductible	80%, After Deductible
	Urgent Care Facility	100%, After Deductible	100%, No Deductible, \$30 Copay	80%, 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	100%, No Deductible	80%, After Deductible
	X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	100%, After Deductible	100%, No Deductible	80%, After Deductible
Ambulance	100%, After Deductible	100%, After Deductible	80%, After Deductible	
Laboratory and Radiology Services (includes pre-admission testing)				
Inpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible	
Outpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible	
Independent X-ray and/or Lab Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible	
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)				
Inpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible	
Outpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible	
Independent Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible	

<p>Maternity Care/Obstetrical Services</p> <p>Physician's Office visit to confirm pregnancy</p> <p>Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)</p> <p>Physician's Office visits in addition to the global maternity fee</p> <p>Laboratory, Radiology Services and or Advance Radiological Imaging</p> <p>Delivery Charges – Facility (Hospital, Birthing Center)</p> <p>Services of a Doula In home or facility up to 10 visits (pre and post-natal combined)</p>	<p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>100%, No Deductible, \$40 Copay</p> <p>100%, After Deductible</p> <p>100%, No Deductible, \$40 Copay</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>Not Covered</p>	<p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>Not Covered</p>
<p>Termination of Pregnancy</p> <p>Medically Necessary</p> <p>Elective</p>	<p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>80%, After Deductible</p> <p>80%, After Deductible</p>
<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%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>100%, No Deductible, \$40 Copay</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p>

<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%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>100%, No Deductible, \$40 Copay</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, 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%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100% of Reasonable Expenses after Plan Deductible</p>	<p>100%, No Deductible, \$40 Copay</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100% of Reasonable Expenses after Plan Deductible</p>	<p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>Not Covered</p>
<p>Transgender Services</p> <p>See benefit description for covered services. 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%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>100%, No Deductible, \$40 Copay</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p> <p>100%, After Deductible</p>	<p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p> <p>80%, After Deductible</p>
<p>Nutritional Evaluation</p> <p>Policy 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%, After Deductible</p>	<p>100%, No Deductible, \$40 Copay</p>	<p>80%, After Deductible</p>

Nutritional Formulas	100%, After Deductible	100%, After Deductible	80%, After Deductible
Acupuncture Physician's office visit Policy Year Maximum of 20 visit limit.	100%, After Deductible	100%, No Deductible, \$40 Copay	80%, After Deductible
Chiropractic Care/Spinal Manipulations Physician's office visit Policy Year Maximum of 20 visit limit.	100%, After Deductible	100%, No Deductible, \$40 Copay	80%, After Deductible
Telehealth	100%, After Deductible	100%, No Deductible, \$30 Copay	80%, After 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%, After Deductible 100%, After Deductible 100%, After Deductible 100%, After Deductible	100%, No Deductible, \$40 Copay 100%, After Deductible 100%, After Deductible 100%, After Deductible	80%, After Deductible 80%, After Deductible 80%, After Deductible 80%, After Deductible
TMJ Treatment	100%, After Deductible	100%, After Deductible	80%, After Deductible
Diabetic Equipment	100%, After Deductible	100%, After Deductible	80%, After Deductible
Durable Medical Equipment	100%, After Deductible	100%, After Deductible	80%, After Deductible
External Prosthetic Appliances	100%, After Deductible	100%, After Deductible	80%, After Deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Policy Year Maximum of \$500	100%, After Deductible	100%, After Deductible	80%, After Deductible

Mental Health			
Inpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	100%, After Deductible	100%, No Deductible, \$30 Copay	80%, After Deductible
Outpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible
Psycho-Educational Testing	100%, After Deductible	100%, After Deductible	80%, After Deductible
Substance Abuse Health			
Inpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	100%, After Deductible	100%, No Deductible, \$30 Copay	80%, After Deductible
Outpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible
Hearing Benefit			
One Examination per 24 month period	100%, After Deductible	100%, No Deductible, \$40 Copay	80%, After Deductible
Hearing Aid Benefit			
Up to \$1,000 per hearing aid unit necessary for each hearing impaired ear every 36 months for each Covered Person age 19 and over	100%, After Deductible	100%, After Deductible	80%, After Deductible
Pediatric Hearing Aid Benefit			
Hearing aid unit for each hearing-impaired ear every 36 months or as medically necessary for a Dependent child age 18 and younger	100%, After Deductible	100%, After Deductible	80%, After Deductible
Home Health Care Services			
Policy Year Maximum of 120 visit limit.	100%, After Deductible	100%, After Deductible	80%, After Deductible
Private Duty Nursing			
Policy Year Maximum of 120 visit limit.	100%, After Deductible	100%, After Deductible	80%, After Deductible

Hospice Care Services	100%, After Deductible	100%, After Deductible	80%, After Deductible
Infusion Therapy			
Outpatient Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible
Physician's Services	100%, After Deductible	100%, After Deductible	80%, After Deductible
Short Term Rehabilitative Therapy			
Policy Year Maximum of 60 visit limit for all therapies combined.			
Physician's Office Visit	100%, After Deductible	100%, No Deductible, \$40 Copay	80%, After Deductible
Outpatient Hospital Facility	100%, After Deductible	100%, After Deductible	80%, After Deductible
Note: The Short Term Rehabilitative Therapy maximum does not apply to the treatment of autism.			

Prescription Drugs

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	\$0 Copayment per Prescription or refill. Deductible does not apply.
Tier 2 Prescription Drugs – Preferred Brand	\$0 Copayment per Prescription or refill. Deductible does not apply.
Tier 3 Prescription Drugs – non Preferred Brand	\$0 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	\$0 Copayment per Prescription or refill. Deductible does not apply.
Tier 2 Prescription Drugs – Preferred Brand	\$0 Copayment per Prescription or refill. Deductible does not apply.
Tier 3 Prescription Drugs – non Preferred Brand	\$0 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.	50% Copayment per Prescription or refill, after Plan Deductible
Tier 2 Prescription Drugs – Preferred Brand	\$50 Copayment per Prescription or refill. Deductible does not apply.	50% Copayment per Prescription or refill, after Plan Deductible
Tier 3 Prescription Drugs – non Preferred Brand	\$75 Copayment per Prescription or refill. Deductible does not apply.	50% Copayment per Prescription or refill, after Plan Deductible

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	\$150 Copayment per Prescription or refill. Deductible does not apply.	Not Covered
Tier 3 Prescription Drugs – non Preferred Brand	\$225 Copayment per Prescription or refill. Deductible does not apply.	Not Covered

Dental Services Rider

<ul style="list-style-type: none"> Policy Year Maximum Combined Benefit for Diagnostic and Preventive Service, Basic Services and Major Services 	\$1,500
<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 Policy Year Dental Deductible <i>Not applicable to Diagnostic and Preventive Services</i> 	\$50
<ul style="list-style-type: none"> Family Maximum 	\$150
<ul style="list-style-type: none"> Per Person Policy Year Orthodontic Deductible 	\$0
<ul style="list-style-type: none"> Diagnostic and Preventive Services 	0%

• Basic Services	20%
• Major Services	50%
• Orthodontic Services <i>Limited to Covered Persons under age 19</i>	50%

Medical Assistance Rider


EMERGENCY MEDICAL EVACUATION	100% of the Actual Cost
REPATRIATION OF MORTAL REMAINS	100% of the Actual Cost
EMERGENCY FAMILY TRAVEL ARRANGEMENTS	Maximum Benefit up to \$5,000

Exclusions, Expenses Not Covered and General Limitations

Additional coverage limitations determined by Plan or Provider type are shown in the Schedule of Benefits. Payment for the following is specifically excluded from this Plan:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if You are legally entitled to such treatment and facilities are reasonably available.
4. For or in connection with an Injury or Sickness which is due to participation in riot, civil commotion or police action.
5. For claim payments that are illegal under applicable law.
6. Charges which You are not obligated to pay or for which You are not billed or for which You would not have been billed except that they were covered under this Plan.
7. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Care or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
8. Non-Treatment Facilities, Institutions or Programs - Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits are provided for Medically Necessary medical or behavioral health treatment received in these locations
9. For or in connection with Experimental, Investigational or unproven services.
Experimental, Investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
 - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
 - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
 - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this Plan; or
 - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this Plan.
10. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

11. The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty for cosmetic reasons; redundant skin surgery; removal of skin tags for cosmetic reasons; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of Obesity, except for treatment of clinically severe (Morbid) Obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of Obesity or clinically severe (Morbid) Obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
13. Unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or Hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
14. Court-ordered treatment or Hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this Plan.
15. Reversal of male or female voluntary sterilization procedures.
16. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
17. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this Plan.
18. Non-medical counseling or ancillary services, including but not limited to Custodial Care services, education, training, vocational rehabilitation, behavioral training, gym or swim therapy, legal or financial counseling, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disabilities.
19. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
20. Family and marital counseling except when Medically Necessary to treat the diagnosed mental or substance use disorder or disorders of a Covered Person.
21. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this Plan.
22. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
23. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and wigs other than for scalp hair prostheses worn due to alopecia areata or due to cancer treatment.
24. Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this Plan as shown in the Schedule of Benefits section. A hearing aid is any device that amplifies sound.
25. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as shown in the Covered Expenses section for treatment of Autism.
26. Vision treatment, eye exercise, equipment or surgery to correct eyesight, such as laser treatment, refractive keratotomy (RK) and photorefractive Keratotomy (PRK). We will pay for eligible treatment or surgery of a detached retina, glaucoma, cataracts or keratoconus.
27. Vision exams, lenses and hardware, including eyeglasses, contact lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye. This Plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
28. All non-injectable Prescription Drugs, injectable Prescription Drugs that do not require Physician supervision and are typically considered self-administered drugs, Non-Prescription Drugs, and Investigational and Experimental drugs, except as provided in this Plan.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
30. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs or voluntary support groups.

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31. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
 32. Dental implants for any condition.
 33. Dental services or supplies except as specifically stated.
 34. Orthodontia services, regardless of condition, including casts, models, X-rays, photographs, examinations, appliances, braces and retainers.
 35. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 36. Blood administration for the purpose of general improvement in physical condition.
 37. Cosmetics, dietary supplements and health and beauty aids.
 38. Drugs, supplies, equipment or procedures to replace hair, slow hair loss or stimulate hair growth.
 39. All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
 40. For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit. This exclusion does not apply if the Group does not furnish Worker's Compensation or Defense Based Act insurance.
 41. Telephone, e-mail, and Internet consultations unless specifically approved by the Administrator due to limited resources while located in a country outside of the United States.

General Limitations

No payment will be made for expenses incurred for You or any one of Your Dependents:

1. For Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such Charges are directly related to a military-service-connected Injury or Sickness.
2. To the extent that You or any one of Your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
3. To the extent that payment is unlawful where the person resides when the expenses are incurred.
4. For Charges which would not have been made if the person had no insurance.
5. To the extent that they are more than Maximum Reimbursable Charges.
6. To the extent of the exclusions imposed by any certification requirement shown in this Plan.
7. Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
8. Charges made by any covered Provider who is a member of Your family or Your Dependent's family.
9. To the extent that such payments would be prohibited by law.

IMPORTANT CONTACT INFORMATION

Contact us *anytime, anywhere!*

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Email us through the **Member Hub**
or **mobile app**



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