BlueCross BlueShield® Global

Welcome to Blue Cross Blue Shield Global®

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

UKPEAGVIK INUPIAT CORPORATION (UIC)

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

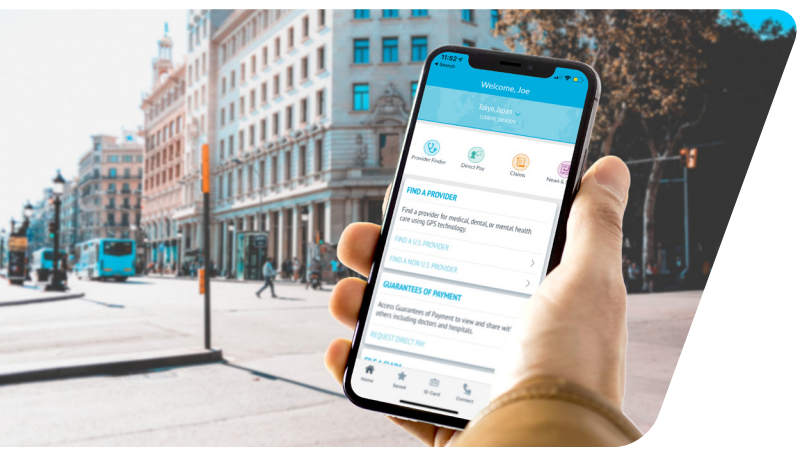
SUBMITTING A CLAIM

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.*

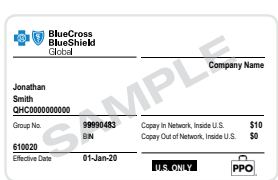
It is important to have your ID card(s) available when receiving healthcare services. Your cards can be accessed from multiple sources:

- 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.



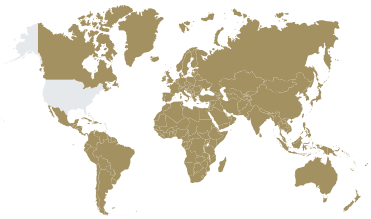
ID card images for illustration purposes only

Need help?

WE'RE AVAILABLE 24/7/365 TO ASSIST

Call the number on the back of your ID card.

*Some policies restrict areas of coverage. Please check your plan certificate of coverage for details, limitations, restrictions and exclusions.



ACCESSING CARE

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

Find a Provider

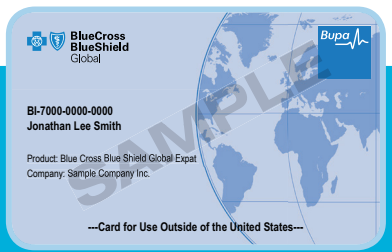
By using your Bupa Global ID card, you have access to one of the largest direct settlement networks outside the U.S.* Simply present your Bupa Global ID card at the point of treatment.

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.

YOUR ID CARD FOR USE OUTSIDE THE U.S.

For illustration purposes only



FIND PROVIDER > **PRESENT ID CARD** > **GET CARE**

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.

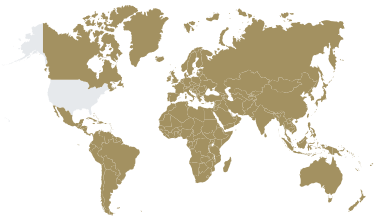
Global TeleMD

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.

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**.

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**.

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.

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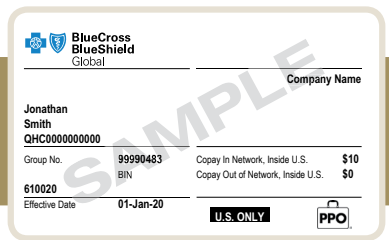


Pre-Authorization

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?

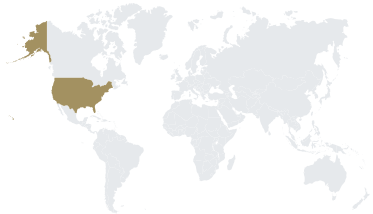
In most cases, when you seek treatment from an in-network provider, they will initiate the pre-authorization process. If you see an out-of-network provider, you are responsible for initiating the pre-authorization process. For more information regarding pre-authorization, please see the Certification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

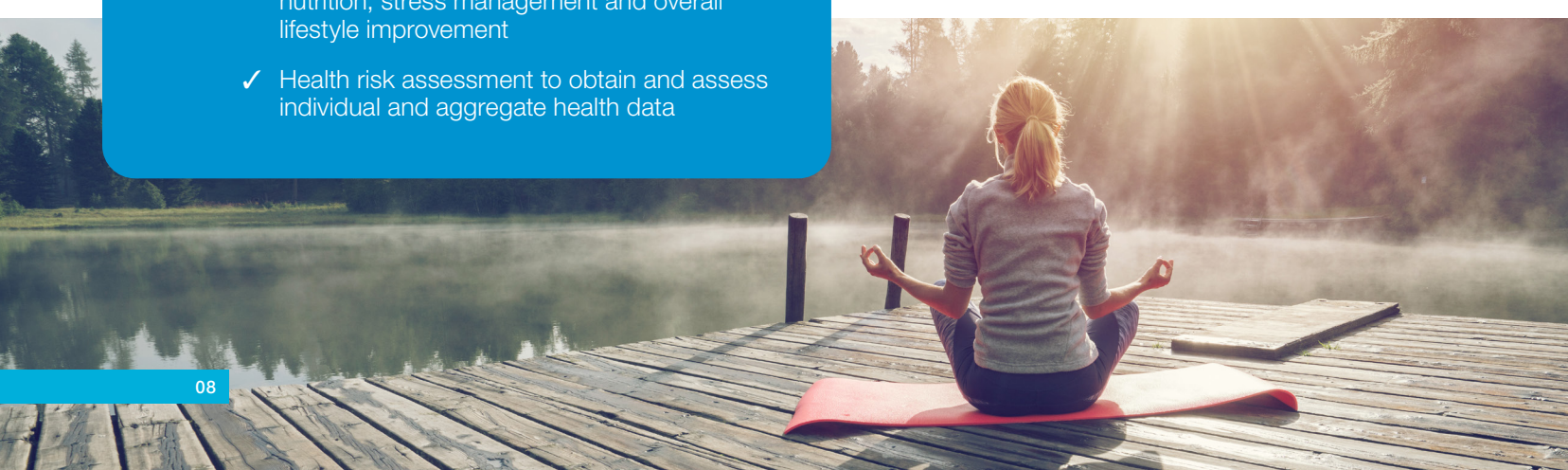
- Inside the U.S.: **1-877-249-4765**
- Outside the U.S.: **+44-208-987-6228**
- **support@worldwideassist.co.uk**

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.

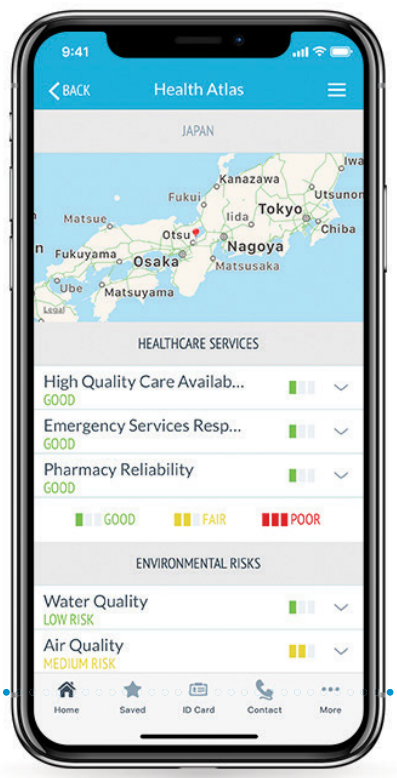
ID Card(s)
Obtain an electronic copy of your ID card(s) and request replacements.

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.

Download on the App Store

GET IT ON Google Play

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.

	Direct Settlement	Pay and Claim
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.

24/7

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

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%	80%	60% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	Not Applicable	85th Percentile of the Maximum Reimbursable Charge
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.			
Policy Year Medical Deductible			
Individual	$0	$0	$1,000
Family Maximum	$0	$0	2.5 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	$2,000	$2,000
Family Maximum	n/a	2.5 times the individual Out-of-Pocket Maximum	2.5 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%	100%, $30 Copay	60%, No Deductible
Office Visit – Specialist	100%	100%, $30 Copay	60%, No Deductible
Surgery Performed In the Physician's Office	100%	80%	60%, After Deductible
Second Opinion Consultations (provided on a voluntary basis)	100%	100%, $30 Copay	60%, No Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Allergy Treatment/Injections	100%	100%, $30 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
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%	80%	60%, After Deductible
Physician's Visits/Consultations	100%	80%	60%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%	80%	60%, After Deductible
Inpatient Services at Other Heath Care Facilities			
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Policy Year Maximum of 120 day limit.	100%	80%	60%, After Deductible
Ambulatory Surgical Services			
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	100%	80%	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%	80%	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	100%	80%	60%, After Deductible
Outpatient Professional Services (radiology, pathology and ER Physician)	100%	80%	60%, After Deductible
Urgent Care Facility	100%	80%	60%, After Deductible
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	100%	80%	60%, After Deductible
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	100%	80%	60%, After Deductible
Ambulance	100%	80%	60%, After Deductible
Laboratory and Radiology Services (includes pre-admission testing)			
Inpatient Facility	100%	80%	60%, After Deductible
Outpatient Facility	100%	80%	60%, After Deductible
Independent X-ray and/or Lab Facility	100%	80%	60%, After Deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)			
Inpatient Facility	100%	80%	60%, After Deductible
Outpatient Facility	100%	80%	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Independent Facility	100%	80%	60%, After Deductible
Maternity Care/Obstetrical Services			
Physician's Office visit to confirm pregnancy	100%	100%, $30 Copay	60%, No Deductible
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	100%	80%	60%, After Deductible
Physician's Office visits in addition to the global maternity fee	100%	100%, $30 Copay	60%, No Deductible
Laboratory, Radiology Services and or Advance Radiological Imaging	100%	80%	60%, After Deductible
Delivery Charges – Facility (Hospital, Birthing Center)	100%	80%	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%	80%	60%, After Deductible
Elective	100%	80%	60%, After Deductible
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%	100%, $30 Copay	60%, No Deductible
Inpatient Facility	100%	80%	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Outpatient Facility	100%	80%	60%, After Deductible
Physician's Services	100%	80%	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%	100%, $30 Copay	60%, No Deductible
Inpatient Facility	100%	80%	60%, After Deductible
Outpatient Facility	100%	80%	60%, After Deductible
Physician's Services	100%	80%	60%, After Deductible
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%	100%, $30 Copay	60%, No Deductible
Inpatient Facility	100%	80%	60%, After Deductible
Outpatient Facility	100%	80%	60%, After Deductible
Physician's Services	100%	80%	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Organ Transplant Services Includes all medically appropriate, non-Experimental transplants. Pre-authorization is required			
Physician's Office Visit	100%	100%, $30 Copay	60%, No Deductible
Inpatient Facility	100%	80%	60%, After Deductible
Physician's Services	100%	80%	60%, After Deductible
Lifetime Travel Maximum: $10,000 per transplant	100% of Reasonable Expenses	100% of Reasonable Expenses	Not Covered
Transgender Services See benefit description for covered services. Pre-authorization is required			
Physician's Office Visit	100%	100%, $30 Copay	60%, No Deductible
Inpatient Facility	100%	80%	60%, After Deductible
Outpatient Facility	100%	80%	60%, After Deductible
Physician's Services	100%	80%	60%, After Deductible
Nutritional Evaluation 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.			
Physician's Office Visit	100%	100%, $30 Copay	60%, No Deductible
Nutritional Formulas	100%	80%	60%, After Deductible
Acupuncture Physician's office visit	100%	100%, $30 Copay	60%, No Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Chiropractic Care/Spinal Manipulations Physician's office visit Policy Year Maximum of 20 visit limit.	100%	100%, $30 Copay	60%, No Deductible
Annual Physical/Executive Health Screening for Services not covered as Preventive Care Policy Year Maximum of $500	100%	80%	60%, No Deductible
Telehealth	100%	100%, $30 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%	100%, $30 Copay	60%, No Deductible
Inpatient Facility	100%	80%	60%, After Deductible
Outpatient Facility	100%	80%	60%, After Deductible
Physician's Services	100%	80%	60%, After Deductible
TMJ Treatment	100%	80%	60%, After Deductible
Diabetic Equipment	100%	80%	60%, After Deductible
Durable Medical Equipment	100%	80%	60%, After Deductible
External Prosthetic Appliances	100%	80%	60%, After Deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Policy Year Maximum of $500	100%	80%	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Mental Health			
Inpatient Facility	100%	80%	60%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	100%	100%, $30 Copay	60%, No Deductible
Outpatient Facility	100%	80%	60%, After Deductible
Psycho-Educational Testing	100%	80%	60%, After Deductible
Substance Abuse Health			
Inpatient Facility	100%	80%	60%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	100%	100%, $30 Copay	60%, No Deductible
Outpatient Facility	100%	80%	60%, After Deductible
Hearing Benefit One Examination per 12 month period	100%	100%, $30 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%	80%	60%, After Deductible
Home Health Care Services Policy Year Maximum of 120 visit limit.	100%	80%	60%, After Deductible
Private Duty Nursing Policy Year Maximum of 120 visit limit.	100%	80%	60%, After Deductible
Hospice Care Services	100%	80%	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Infusion Therapy			
Outpatient Facility	100%	80%	60%, After Deductible
Physician's Services	100%	80%	60%, After Deductible
Short Term Rehabilitative Therapy Policy Year Maximum of 30 visit limit for all therapies combined.			
Physician's Office Visit	100%	100%, $30 Copay	60%, No Deductible
Outpatient Hospital Facility	100%	80%	60%, After Deductible
Note: The Short Term Rehabilitative Therapy maximum does not apply to the treatment of autism.			

Exclusions and Expenses Not Covered

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 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. Infertility, Assisted Reproduction And Sterilization Reversal
    a. Treatment of Infertility, including procedures, supplies and drugs;
    b. Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof;

    Please Note: This exclusion does not apply to the diagnosis of Infertility or the surgical correction or a condition causing Infertility. This would be treated the same as any other medical condition.
16. Reversal of male or female voluntary sterilization procedures.
17. 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.
18. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this Plan.
19. 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.
20. 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.
21. Family and marital counseling except when Medically Necessary to treat the diagnosed mental or substance use disorder or disorders of a Covered Person.
22. 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.
23. 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.
24. 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.
25. 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.

26. 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.
27. 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.
28. 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.
29. 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.
30. 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.
31. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs or voluntary support groups.
32. 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.
33. Dental implants for any condition.
34. Dental services or supplies except as specifically stated.
35. Orthodontia services, regardless of condition, including casts, models, X-rays, photographs, examinations, appliances, braces and retainers.
36. 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.
37. Blood administration for the purpose of general improvement in physical condition.
38. Cosmetics, dietary supplements and health and beauty aids.
39. Drugs, supplies, equipment or procedures to replace hair, slow hair loss or stimulate hair growth.
40. All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
41. 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.
42. 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.

Prescription Drugs - Schedule of Benefits

Prescription Drugs **Schedule of Benefits**
The below section describes the coverage for Prescriptions Drugs for You and Your insured Dependents. The Plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in the Schedule of Benefits and as described in the Prescription Drug Coverage section of this Certificate. To receive Prescription Drug Benefits, You and Your Dependents may be required to pay a portion of the Covered Expenses. That portion includes any applicable Deductible and/or Copayments. Benefits are limited as described in the Prescription Drug section of this Certificate and are subject to the Medical "Exclusions" section of this Certificate.
The following are applicable to all Prescription Drug benefits:
• The Prescription drug designation is as per generally-accepted industry sources and adopted by Us and is subject to change

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.
Tier 2 Prescription Drugs – Preferred Brand	$10 Copayment per Prescription or refill.
Tier 3 Prescription Drugs – non Preferred Brand	$10 Copayment per Prescription or refill.
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.
Tier 2 Prescription Drugs – Preferred Brand	$30 Copayment per Prescription or refill.
Tier 3 Prescription Drugs – non Preferred Brand	$30 Copayment per Prescription or refill.

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.	$10 Copayment per Prescription or refill. Deductible does not apply.
Tier 2 Prescription Drugs – Preferred Brand	$25 Copayment per Prescription or refill.	$25 Copayment per Prescription or refill. Deductible does not apply.
Tier 3 Prescription Drugs – non Preferred Brand	30% Copayment per Prescription or refill. 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.	**Not Covered**
Tier 2 Prescription Drugs – Preferred Brand	$75 Copayment per Prescription or refill.	**Not Covered**
Tier 3 Prescription Drugs – non Preferred Brand	30% Copayment per Prescription or refill. The Maximum Copayment per 3 month supply is $450.	**Not Covered**

Exclusions

No payment will be made for the following expenses:

1. drugs available over the counter that do not require a Prescription by federal or state law or applicable law in the jurisdiction where the drug is purchased;
2. any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
3. a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
4. Contrary to approved medical and professional standards: Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice;
5. Compound drugs. Case by case review is available for unique patient clinical circumstances where the only solution is to provide a compounded medicine. See the Drug Utilization Review section of this benefit;
6. Fixed Dose Combination drugs that are not supported by medical and/or pharmaceutical literature describing a therapeutic advantage in clinical outcomes to the same or similar separately administered medicines in comparable daily doses. Case by case review is available for unique patient clinical circumstances where the only solution is to provide a Fixed Dose Combination drug. See the Drug Utilization Review section of this benefit
7. Injectable Infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
8. Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal and meets accepted clinical criteria for use;
9. prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
10. prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
11. implantable contraceptive products;
12. weight management drugs;
13. diet pills or appetite suppressants (anorectics);
14. anabolic steroids;
15. growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
16. prescription smoking cessation products;
17. biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
18. drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
19. drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in oral, injectable and topical forms or any other form used internally or externally;
20. replacement of Prescription Drugs and Related Supplies due to loss or theft;
21. drugs used to enhance athletic performance;
22. drugs which are to be taken by or administered to You while You are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
23. Prescriptions more than one year from the original date of issue;
24. any drugs that are Experimental or Investigational as described under the Medical “Exclusions” section of Your Certificate.

Dental Services Rider

Dental Benefit Maximum

The maximum amount of dental benefits available to any one Covered Person is shown below.

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

Benefits for Covered Services with multiple treatment dates are subject to the dental benefit maximum of the Policy Year in which the services are started.

However, if You receive dental implant services, the post insertion and the final crown or bridgework will be considered to be separate services, and those services will be calculated under the Policy Year limitation in which they are received.

Providers

The Dental Benefits offered includes Participating and non- Participating Providers. This Plan is designed to cover all Dental Care Providers at the same benefit level.

You may be required to submit the dental claim Yourself if Your Dental Care Provider does not do this for You. Please see the "How Do I File A Claim?" section in this booklet for instructions on submitting claims for reimbursement.

Benefit Percentages

After You satisfy the required Policy Year Deductible if one applies, You pay the following Coinsurance per Policy Year, up to the dental benefit maximum. Dental services fall into 4 categories: Diagnostic and Preventive services, Basic services, Major services and Orthodontic services. In this section You will find a description of the services included in each category.

• Diagnostic and Preventive Services	0%
• Basic Services	20%
• Major Services	50%
• Orthodontic Services *Limited to Covered Persons under age 19*	50%

Vision Care Rider

We will pay for Covered Services as stated below for routine Vision Care that is not the result of an Injury or Sickness. The Deductible is not applicable.

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

Your coverage includes benefits for vision care when You receive such care from a Physician, Optometrist or Optician. The benefits of this section are subject to all of the terms and conditions of the Certificate. For vision care benefits to be available such care must be Medically Necessary and rendered and billed for by a Physician, Optometrist or Optician, and You must receive such care on or after Your Effective Date. In addition to the definitions of this Certificate, the following definitions are applicable to this Benefit Section:

Contact Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on Your eye.

Frame means a standard eyeglass frame adequate to hold Lenses.

Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

Covered Services
Benefits may be provided under this Benefit Section for the following:

- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses;
- One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms) covered up to Plan allowance;
- Frames – One frame – choice of frame covered up to Plan allowance;
- Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

Special Limitations/Expenses Not Covered
Benefits will not be provided for the following:

1. Prescription sunglasses;
2. Medical or surgical treatment of the eyes;
3. Orthoptic or vision training and any associated supplemental testing;
4. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
5. Magnification or low vision aids;
6. Any non-prescription eyeglasses, lenses, or contact lenses;
7. Safety glasses or lenses required for employment;
8. Charges in excess of the Maximum Reimbursable Charge for the Service or Materials;
9. Charges incurred after the Policy ends or the Covered Person's coverage under the Policy ends; and
10. Experimental or non-conventional treatment or device.

Medical Assistance Rider

We will pay for Covered Services up to the maximum stated below per Policy Year, unless otherwise stated, for the medical assistance services listed below. The Deductible is not applicable.

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

Emergency Medical Evacuation Benefit

If You suffer a life-threatening/limb-threatening medical condition, and We, and/or Our designee, determines that adequate medical facilities are not available locally, We, or Our designee, will arrange for an emergency evacuation to the nearest facility capable of providing adequate care. You must contact Us at the phone number indicated on Your identification card to begin this process.

In making a determination, We, and/or Our designee, will consider the nature of the emergency, Your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered. Your medical condition must require the accompaniment of a qualified healthcare professional during the entire course of Your evacuation to be considered an emergency and requiring emergency evacuation.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

As part of a medical evacuation, the Administrator shall also make all necessary arrangements for ground transportation to and from the Hospital, as well as pre-admission arrangements, where possible, at the receiving Hospital.

Repatriation

Following any covered emergency evacuation, We will pay for one of the following:

1. If it is deemed Medically Necessary, You will be transferred to Your permanent residence via a one-way economy airfare or;
2. You will be transferred back to Your original work location or the location from which You were evacuated via a one-way economy airfare.

If Your transportation needs to be medically supervised a qualified medical attendant will escort You. Additionally, if We and/or Our designee determine a mode of transport other than economy class seating on a commercial aircraft is required, We or Our designee will arrange accordingly and such will be covered by Us.

Return of Dependent Children

If You have minor children who are left unattended as a result of Your Injury, Sickness or medical evacuation, We or Our designee will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to Your Home Country or country of assignment.

Repatriation of Mortal Remains Benefit

If You die while covered under this Policy, We will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to Your Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by Us or Our designee.

No benefit is payable if the death occurs after the termination date of the Policy. We will not pay any claims under this provision unless the expense has been approved by the Administrator before the body is prepared for transportation.

The benefit for all necessary Repatriation or Mortal Remains services are listed above.

Emergency Family Travel Arrangements Benefit

If We determine that You are expected to require hospitalization in excess of 7 days at the location to which You are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by You. If Your Dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.

If We determine that You are expected to require hospitalization due to an Injury or Sickness for more than 7 days or are in critical condition while traveling outside of Your Home Country, We will pay up to the maximum benefit as listed above for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the location of Your Hospital Confinement for one person designated by You. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

The benefit for all necessary Emergency Family Travel Arrangements is listed above.

General Limitations/Exclusions for Evacuation Benefits

No payment will be made for charges for:

1. Services rendered without the authorization or intervention of Us or Our designee;
2. Non-emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to You;
3. A condition which would allow for treatment at a future date convenient to You and which does not require emergency evacuation or repatriation;
4. Medical care or services scheduled for You or Your Provider's convenience which are not considered an emergency;
5. Expenses incurred if the original or ancillary purpose of Your trip is to obtain medical treatment;
6. Services provided for which no charge is normally made;
7. Expenses incurred while serving in the armed forces of another country;
8. Transportation for Your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
9. Service provided other than those indicated in this rider;
10. For claim payments that are illegal under applicable law.

IMPORTANT CONTACT INFORMATION

*Contact us **anytime, anywhere!***

REACH US WORLDWIDE 24/7/365:

Outside the U.S.
+1-610-230-2406

Toll-free within the U.S.
1-888-304-8898

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

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