Global Medical Insurance Platinum

IMPORTANT NOTICE REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA):

This insurance is not subject to, and does not provide benefits required by, PPACA. PPACA requires United States. citizens, United States. nationals and resident-aliens to obtain PPACA compliant insurance coverage unless they are exempt from PPACA. Penalties may be imposed on persons who are required to maintain PPACA compliant coverage but do not do so.

Eligibility to purchase or renew this product, or its terms and conditions, may be modified or amended based upon changes to applicable law, including PPACA. Please note that it is solely the Insured Person's responsibility to determine if the insurance requirements apply to him/her, and the Company and its Administrator shall have no liability whatsoever, including for any penalties that the Insured Person may incur, for their failure to obtain coverage required by any applicable law including without limitation PPACA.

BENEFIT SUMMARY: MEDICAL

Coverage Limit / Maximum Amount for Eligible Medical Expenses				
Period of Coverage	Maximum Limit: 365 days			
Area of Coverage	Area 2: Worldwide excluding United States, Canada, China, Hong Kong, Japan, Macau, Singapore and Taiwan. United States 30-day maximum per Period of Coverage for Emergency Illness or Accident only. Treatment in the United States must be received from a Physician, Hospital or other healthcare provider within the Preferred Provider Network (PPO).			
	Area 3: Worldwide			
Lifetime Maximum	$8,000,000			
Medical Concierge • Non-emergency services only	The Medical Concierge Service is a proprietary service of IMG that helps an Insured Person navigate the United States healthcare system to identify the highest quality providers for scheduled Inpatient and certain Outpatient Treatments. Refer to the MEDICAL CONCIERGE provision for further details.			
Benefit Plan Features (Subject to Area of Coverage indicated on the Declaration)				
United States: 50 states and the District of Columbia International: United States territories and countries other than the United States	**United States** Medical Concierge	**United States** In-Network	**United States** Out-of-Network	**International** International
Deductible for Eligible Medical Expenses				
Deductible • Refer to Declaration for Deductible amount	50% reduction of Deductible or maximum of $2,500	100% of Deductible	100% of Deductible	50% reduction of Deductible or maximum of $2,500
Coinsurance for Eligible Medical Expenses				
Coinsurance • In addition to Deductible	Plan pays 100% Insured pays 0%	Plan pays 100% Insured pays 0%	Plan pays 80% Insured pays 20%	Plan pays 100% Insured pays 0%
Out of Pocket Maximum	$0	$0	$1,000	$0
Pre-certification				
• Transplants: No coverage if Pre-certification requirements are not met. • Interfacility Ambulance Transfer: No coverage if Pre-certification requirements are not met. • Medical Evacuation: No coverage if Pre-certification requirements are not met. Refer to the MEDICAL EVACUATION provision for further details and requirements. • Orphan Drugs or Biologic Drugs: No coverage if not approved in writing by the Company or Plan Administrator. • All other Treatments & supplies: 50% reduction of Eligible Medical Expenses if Pre-certification requirements are not met. • Deductible is taken after reduction. • Coinsurance is applied to remainder of the reduced amount. • Refer to PRE-CERTIFICATION REQUIREMENTS provision for a complete list of services that require Pre-certification.				

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Eligible Medical Expenses	100%	100%	80%	100%
Outpatient Physician / Specialist Visit	Not Applicable	100%	80%	100%
Physician Visits / Services	100%	100%	80%	100%
Teladoc Consultation • For Insured Persons with Area 3 coverage only • Coverage for a Teladoc Consultation is not a determination that any specific condition discussed, raised or identified during such consultation is covered under this insurance. The Company reserves the right to decline future claims relating to or arising from any condition discussed, raised or identified during a Teladoc Consultation where the Illness or Injury is directly or indirectly related to any Pre-existing Condition or is otherwise excluded under this Certificate of Insurance.	Not Applicable	100%	Not Applicable	Not Applicable
Hospital Emergency Room: United States • Injury: Not subject to Emergency Room Deductible • Illness: Subject to a $250 Deductible for each Emergency Room visit for Treatment that does not result in a direct Hospital admission	Not Applicable	100%	80%	Not Applicable
Hospital Emergency Room: International	Not Applicable	Not Applicable	Not Applicable	100%
Hospitalization / Room & Board • Average private room rate • Includes nursing, miscellaneous and Ancillary Services	100%	100%	80%	100%
Intensive Care	100%	100%	80%	100%
Outpatient Surgical / Hospital Facility	100%	100%	80%	100%
Laboratory	Not Applicable	100%	80%	100%
Radiology / X-ray	100%	100%	80%	100%
Chemotherapy / Radiation Therapy	Not Applicable	100%	80%	100%
Pre-admission Testing	Not Applicable	100%	80%	100%
Surgery	100%	100%	80%	100%
Reconstructive Surgery • Surgery is incidental to or follows Surgery that was covered under the plan	100%	100%	80%	100%
Assistant Surgeon • 20% of the primary surgeon's eligible fee	Not Applicable	100%	80%	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Second Surgical Opinion • Payable at 100% if requested by the Company • 50% reduction of Eligible Medical Expenses for failure to obtain a Second Surgical Opinion when required by the Company	Not Applicable	100%	80%	100%
Anesthesia	Not Applicable	100%	80%	100%
Maternity • Available after 10 months of continuous coverage • Maternity Deductible: $2,500 • In addition to plan Deductible • Lifetime Maximum: $50,000	Not Applicable	100%	80%	100%
Newborn Care / Congenital Disorders • Maximum Limit: $250,000 • Eligible if the Pregnancy is covered under the plan • Routine Care during the first 31 days of life including Medically Necessary Treatment of Congenital Disorders	Not Applicable	100%	80%	100%
Newborn Wellness • Not subject to Deductible and Coinsurance • Maximum Limit: $200 • Eligible if the Pregnancy is covered under the plan • Routine Care after 31 days of life through 12 months	Not Applicable	100%	100%	100%
Durable Medical Equipment	Not Applicable	100%	80%	100%
Podiatry Care • Maximum Limit: $750	Not Applicable	100%	80%	100%
Physical Therapy • Maximum Limit per visit: $50 • Maximum visits per day: 1 • Medical order or Treatment plan required	Not Applicable	100%	80%	100%
Extended Care Facility • Upon direct transfer from an acute care Facility	100%	100%	80%	100%
Home Nursing Care • Provided by a Home Health Care Agency • Upon direct transfer from an acute care Facility	100%	100%	80%	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Hospice • Terminally ill – 6 months to live • Inpatient Hospice Facility • Insured Person's home	100%	100%	80%	100%
Transplant • Lifetime Maximum: $2,000,000 • Transplant Maximum Limit: 1 • Organ procurement & harvesting costs Lifetime Maximum: $20,000 • Travel & lodging Lifetime Maximum expense: $10,000 • Covered Transplants: cornea, heart, heart/lung, lung, kidney, kidney/pancreas, liver, allogeneic or autologous bone marrow • Subject to the TRANSPLANT PRE-CERTIFICATION provision and only when Treatment is provided within the Company's approved independent Managed Transplant System Network	100%	100%	Not Applicable	100%
Prescription Drugs and Medication NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
The following categories listed immediately below accumulate toward the Lifetime Maximum.				
United States Retail Pharmacy Prescriptions • Copayments are per 30-day supply • Dispensing maximum per prescription: 90 days	Universal RX (URX) Prescription Drug Card MUST be utilized for all Outpatient Prescription Drugs in the United States. Retail Pharmacy Copayments: Generic: $20 Brand (when Generic is unavailable): $40			
International Retail Pharmacy Prescriptions • Subject to Deductible • Dispensing maximum per prescription: 90 days	Coinsurance: 100%			
Expatriate Prescription Services Program • Copayments are per 30-day supply • Dispensing Maximum per prescription: 180 days	Generic: $20 Non-preferred Brand Name: $40 Contact Information: • Enroll: via the provider's website www.expatps.com • Prescription submission: • Email (scan prescription): epsmanager@universalrx.com • Fax: +1.540.777.7184 Questions/Concerns: • Phone number: +1.540.777.1450 • Email: epsmanager@universalrx.com			

Prescription Drugs and Medication Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum	
The following category applies toward the Period of Coverage Maximum Limit. The Maximum Limit applies towards the Lifetime Maximum.	
Orphan Drugs or Biologic Drugs, but only when ALL the following are met: • Approved in writing by the Company or Plan Administrator • Is Medically Necessary and generally accepted standard of medical practice; and • Is not Experimental or Investigational.	Maximum Limit: $250,000 For Orphan Drugs or Biologic Drugs obtained through: • United States Retail Pharmacy and Expatriate Prescription Services Program: Subject to Copayments stated above • International Retail Pharmacy: Subject to Deductible and Coinsurance stated above For Orphan Drugs or Biologic Drugs obtained through: • Inpatient/Outpatient Medical Treatment: Subject to Deductible and Coinsurance

Preventative Care NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Adult Preventative Care • Ages 19 and older • Maximum Limit: $500	Not Applicable	100%	100%	100%
Child Preventative Care • Ages 18 and younger • Maximum Limit: $400	Not Applicable	100%	100%	100%

Vision Care NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum	
Routine Eye Examination	Maximum Limit every 24 months: $100
Corrective Lenses, Contacts, Frame	Maximum Limit every 24 months: $150

Mental or Nervous and Counseling Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
Mental or Nervous • After 12 months of continuous coverage • Lifetime Maximum: $50,000	Not Applicable	100%	80%	100%
Bereavement Counseling • Not subject to Deductible and Coinsurance • Lifetime Maximum: $300 • Counseling 6 months before or after a Family member's death	Not Applicable	100%	100%	100%

Emergency Services NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Emergency Local Ambulance • Injury • Illness resulting in an Inpatient Hospital admission	Not Applicable	100%	100%	100%
Emergency Medical Evacuation • Up to the Lifetime Maximum • Approved in advance and coordinated by the Company	Not Applicable	100%	100%	100%
Emergency Reunion • Lifetime Maximum: $10,000 • Maximum days: 15 • Meal Maximum Limit per day: $25 • Reasonable and necessary travel costs and accommodations • Approved in advance by the Company	Not Applicable	100%	100%	100%
Interfacility Ambulance Transfer • United States only • Transfer from one licensed health care Facility to another licensed health care Facility	Not Applicable	100%	80%	Not Applicable
Political Evacuation and Repatriation • Lifetime Maximum: $10,000 • Approved in advance by the Company	Not Applicable	100%	100%	100%
Remote Transportation • Maximum Limit: $5,000 • Lifetime Maximum: $20,000 • Approved in advance by the Company	Not Applicable	100%	100%	100%
Return of Mortal Remains • Maximum Limit: $50,000 • Local Burial / Cremation Maximum Limit: $5,000 • Return of Insured Person's Mortal Remains to Country of Residence • Approved in advance by the Company	Not Applicable	100%	100%	100%

Other Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Complementary Medicine • Maximum Limit: $500 • Services include Acupuncture, Aromatherapy, Herbal Therapy, Magnetic Therapy, Massage Therapy and Vitamin Therapy	Not Applicable	100%	100%	100%
Traumatic Dental Injury • Up to the Lifetime Maximum • Treatment at a Hospital Facility due to an Accident • Additional Treatment for the same Injury rendered by a Dental Provider will be paid at 100%	Not Applicable	100%	80%	100%
High School Sports • Lifetime Maximum: $20,000 • Includes Collision Sports	Not Applicable	100%	80%	100%
Healthy Travel Preventative Coverage • Not subject to Deductible and Coinsurance • Adult and Child • Vaccinations and preventative prescription drugs administered by a Physician within 30 days prior to the Insured Person's Initial Effective Date and before departing to any destination • Lifetime Maximum: $250 • Refer to the HEALTHY TRAVEL PREVENTATIVE COVERAGE provision for further details and requirements	Not Applicable	100%	100%	100%
Hospital Indemnity • Not subject to Deductible and Coinsurance • International only • Inpatient Hospitalization only	Private Hospital • Overnight Maximum Limit: $400 • Maximum Limit: $4,000 Public Hospital (state, government or charitable Hospital) • Overnight Maximum Limit: $500 • Maximum Limit: $5,000 Treatment received by the Insured Person at a Public Hospital and no Charges are incurred by the Insured Person or the Company will be subject to the Public Hospital Maximum Limit. Treatment received by the Insured Person at a Public Hospital and Charges are submitted to the Company for reimbursement will be subject to the Private Hospital Maximum Limit.			

Other Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum				
Benefit	**Medical Concierge (Non-emergency)**	**In-Network**	**Out-of-Network**	**International**
Supplemental Accident • Not subject to Deductible and Coinsurance • Maximum Limit per Accident: $500 • Charges will be subject to Deductible and Coinsurance and paid the same as any other Injury once the Maximum Limit has been satisfied	Not Applicable	100%	100%	100%

BENEFIT SUMMARY: DENTAL

Coverage Limit / Maximum Amount for Eligible Dental Expenses		
Period of Coverage Maximum Limit	$750	
Deductible • Applies to Minor and Major Restorative Services	$50	
Dental Services After 6 months of continuous coverage		
Routine Services NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Expenses are limited to Usual, Reasonable and Customary amounts Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum		
Benefit	**Coinsurance**	
Diagnostic and Preventative Services • Preventative visits and cleanings: 2 (1 every 6 months) • Radiographic examinations (including posterior bitewings): 2 (1 every 6 months) • Fluoride Treatment: 1 for Children under age 19	Plan Pays 90%	Insured Pays 10%
Emergency Palliative Treatment	Plan Pays 90%	Insured Pays 10%
Minor Restorative Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum		
Radiographs • Radiograph: 1 every 3 years • Full mouth x-rays including panographic x-rays	Plan Pays 70%	Insured Pays 30%
Oral Surgery	Plan Pays 70%	Insured Pays 30%
Endodontics	Plan Pays 70%	Insured Pays 30%
Periodontics • Root planning: 1 every 2 years • Periodontal Surgery: 1 every 3 years	Plan Pays 70%	Insured Pays 30%
Minor Restorative Services • Refer to the ELIGIBLE DENTAL EXPENSES provision for further details and requirements	Plan Pays 70%	Insured Pays 30%
Major Restorative Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum		
Major Restorative Services • Crowns, jackets, inlays (on same tooth): 1 every 5 years • Limitations apply for Children under age 12 • Refer to the ELIGIBLE DENTAL EXPENSES provision for further details and requirements	Plan Pays 50%	Insured Pays 50%

Major Restorative Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Maximum Limit per Period of Coverage or if indicated, Lifetime Maximum		
Benefit	**Coinsurance**	
Prosthodontics • Dentures / bridges: 1 every 5 years • Replacement of denture base material or reline: 1 every 3 years • Refer to the ELIGIBLE DENTAL EXPENSES provision for further details and requirements	Plan Pays 50%	Insured Pays 50%