

TPG Cultural Exchange

This section is a summary and a full description of the benefits covered under this group policy. Please read the benefit descriptions for complete details of your coverage. All covered benefits are subject to: (i) your cost share amounts and any benefit maximums listed on your summary of benefits; (ii) the Usual, Reasonable and Customary Charges; and (iii) any limitations and exclusions. Any service, supply or prescription drug which is: (a) not ordered, recommended, or approved by a physician; (b) not rendered under the scope of a physician's license; or (c) not medically necessary or in accordance with established evidence based medicine will not be covered.

Area of Coverage	Worldwide excluding home country
Maximum Limit per Injury or Illness	\$100,000

**The Deductible for In-Network does not accrue towards the Out-of-Network Deductible.
Copayments do not apply to the Deductible or the Out-of-Pocket Maximum.
The Deductible does not apply to the Out-of-Pocket Maximum.**

	In-Network	Out-of-Network
Deductible per Injury or Illness	\$100	\$100
Coinsurance	Plan pays 90% Insured person pays 10%	Plan pays 60% Insured person pays 40%
Out-of-Pocket Maximum	\$500	\$2,000
Acute Onset of Pre-Existing Conditions	Age 65 and under up to the Maximum Limit per Injury or Illness. Refer to the Acute Onset of Pre-Existing Conditions full benefit description in the Policy for coverage and limitations.	
<ul style="list-style-type: none"> Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Limits per Policy Period unless stated as Maximum Limit 		

Preventive Care Services are NOT subject to Deductible and Coinsurance amounts unless otherwise noted. Eligible Medical Expenses are limited to Usual, Reasonable and Customary Charges per Policy Period and may be subject to a Maximum Benefit limit.

	In-Network	Out-of-Network
Preventative Care		
<ul style="list-style-type: none"> Maximum Limit: \$250 Routine Physical Examinations and routine inoculations / vaccinations 	100%	100%

Inpatient and Outpatient Services are subject to Deductible and Coinsurance amounts unless otherwise noted. Eligible Medical Expenses are limited to Usual, Reasonable and Customary Charges per Policy Period and may be subject to a Maximum Benefit limit.

	In-Network	Out-of-Network
Physician / Specialist Visit		
Maximum Visits per day: 1 (unless visit is for a different medical/surgical specialty)	90%	60%
Teladoc Consultation		
<ul style="list-style-type: none"> Applicable in the United States Not Subject to Deductible and Coinsurance Coverage for a Teladoc Consultation is not a determination that any specific condition discussed, raised or identified during such consultation is covered under this Policy. <p>WellAway 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 Policy.</p>	100%	N/A

Inpatient and Outpatient Services are subject to Deductible and Coinsurance amounts unless otherwise noted. Eligible Medical Expenses are limited to Usual, Reasonable and Customary Charges per Policy Period and may be subject to a Maximum Benefit limit.

	In-Network	Out-of-Network
Urgent Care Clinic <ul style="list-style-type: none"> Not subject to Deductible Copayment: \$25 	90%	60%
Walk-in Clinic <ul style="list-style-type: none"> Not subject to Deductible Copayment: \$25 	90%	60%
Hospital Emergency Room <i>Note: Non-Emergency services are not covered.</i> Injury: Not subject to Emergency Room Deductible but subject to plan Deductible Illness: Subject to \$350 Deductible for each Emergency Room visit. Emergency Room Deductible will be waived if admitted, subject to plan Deductible.	90%	60%
Pre-admission Testing	90%	60%
Hospitalization / Room & Board* <ul style="list-style-type: none"> Average semi-private room rate Includes nursing, miscellaneous and Ancillary Services 	90%	60%
Intensive Care*	90%	60%
Outpatient Surgical / Hospital Facility*	90%	60%
Laboratory	90%	60%
Radiology / X-ray	90%	60%
Advance Diagnostics	90%	60%
Surgery*	90%	60%
Reconstructive Surgery* <ul style="list-style-type: none"> Surgery is incidental to or follows Surgery that was covered under the plan 	90%	60%
Assistant Surgeon <ul style="list-style-type: none"> 20% of the primary surgeon's eligible fee 	90%	60%
Chemotherapy / Radiation Therapy*	90%	60%
Inpatient Mental or Nervous Disorder* <ul style="list-style-type: none"> Maximum days: 45 Maximum Limit: \$10,000 	50%	50%
Outpatient Mental or Nervous Disorder <ul style="list-style-type: none"> Maximum Limit: \$500 	80%	80%
Chiropractic Care <ul style="list-style-type: none"> Maximum per day: \$25 Limit: \$2,500 Treatment plan required 	90%	60%
Physical Therapy <ul style="list-style-type: none"> Maximum Visits per day: 1 Treatment plan required 	90%	60%
Extended Care Facility* <ul style="list-style-type: none"> Upon direct transfer from Hospital 	90%	60%
Home Nursing Care* <ul style="list-style-type: none"> Provided by a Home Health Care Agency Upon direct transfer from Hospital 	90%	60%
Durable Medical Equipment	90%	60%

* Pre-authorization required

Prescription Medications are subject to Deductible and Coinsurance amounts unless otherwise noted. Eligible Medical Expenses are limited to Usual, Reasonable and Customary Charges per Policy Period and may be subject to a Maximum Benefit limit.

	In-Network	Out-of-Network
Prescriptions <ul style="list-style-type: none"> Dispensing Maximum: 90 days per prescription per injury or illness 	80%	80%

Emergency Transportation Services are NOT subject to Deductible and Coinsurance amounts unless otherwise noted. Eligible Medical Expenses are limited to Usual, Reasonable and Customary Charges per Policy Period and may be subject to a Maximum Benefit limit.

	In-Network	Out-of-Network
Emergency Local Ambulance <ul style="list-style-type: none"> Subject to Deductible and Coinsurance Covered for Injury Covered for Illness only if admitted to Hospital 	90%	60%
Emergency Medical Evacuation* <ul style="list-style-type: none"> Maximum Limit: \$50,000 Maximum Limit: \$25,000 for Acute Onset of Pre-Existing condition Approved in advance and coordinated by the Plan Administrator 	100%	100%
Bedside Visit <ul style="list-style-type: none"> Not subject to Deductible Maximum Limit: \$1,500 Only applicable if Insured Person is hospitalized in an intensive care unit. Refer to the Bedside Visit full benefit description in the Policy for coverage and limitations. 	90%	60%
Interfacility Ambulance Transfer* <ul style="list-style-type: none"> Transfer must be a result of an Inpatient Hospital admission 	100%	100%
Natural Disaster Evacuation* <ul style="list-style-type: none"> Maximum Limit: \$25,000 Approved in advance by the Plan Administrator 	100%	100%
Political Evacuation and Repatriation* <ul style="list-style-type: none"> Maximum Limit: \$100,000 Approved in advance by the Plan Administrator 	100%	100%
Return of Minor Children* <ul style="list-style-type: none"> Maximum Limit: \$100,000 Approved in advance by the Plan Administrator 	100%	100%
Return of Mortal Remains* <ul style="list-style-type: none"> Maximum Limit: \$100,000 Local Burial / Cremation Maximum Limit: \$5,000 Return of Insured Person's Mortal Remains to Home Country Approved in advance by the Plan Administrator 	100%	100%

* Pre-authorization required

Other Services are NOT subject to Deductible and Coinsurance amounts unless otherwise noted. Eligible Medical Expenses are limited to Usual, Reasonable and Customary Charges per Policy Period and may be subject to a Maximum Benefit limit.

	In-Network	Out-of-Network
<p>Accidental Death & Dismemberment</p> <ul style="list-style-type: none"> Principal Sum Maximum: \$50,000 Death must occur within 90 days of the Accident 	<p>Accidental Death: 100% of Principal Sum</p> <p>Accidental Dismemberment:</p> <p>Loss Percent of Principal Sum</p> <p>Sight of 1 eye 50%</p> <p>1 hand or 1 foot 50%</p> <p>1 hand and loss of sight of 1 eye 100%</p> <p>1 foot and loss of sight of 1 eye 100%</p> <p>1 hand and 1 foot 100%</p> <p>Both hands or both feet 100%</p> <p>Sight of both eyes 100%</p>	
<p>Traumatic Dental Injury</p> <ul style="list-style-type: none"> Subject to Deductible and Coinsurance Treatment at a Hospital due to an Accident Additional Treatment for the same Injury rendered by a Dental Provider will be paid at 100% 	90%	60%
<p>Emergency Eye Examination</p> <ul style="list-style-type: none"> Subject to Coinsurance Deductible per occurrence: \$50 (plan Deductible waived) Maximum Limit: \$150 Loss or damage to prescription corrective lenses due to an Accident 	90%	60%
<p>Incidental Trip</p> <ul style="list-style-type: none"> Maximum days: 14 Home Country is outside the United States 	100%	100%
<p>Lost Luggage</p> <ul style="list-style-type: none"> Maximum Limit: \$500 Maximum Limit: \$50 per item 	100%	100%
<p>Natural Disaster</p> <ul style="list-style-type: none"> Limit per day: \$250 Maximum days: 5 	100%	100%
<p>Personal Liability</p> <ul style="list-style-type: none"> Secondary to any other insurance No coverage for injury to a related third party or damage to related third person's property Refer to the Personal Liability full benefit description in the Policy for coverage and limitations. 	<p>Combined Maximum Limit: \$25,000</p> <p>Injury to third person:</p> <ul style="list-style-type: none"> Per Injury Deductible: \$100 <p>Damage to third person's property:</p> <ul style="list-style-type: none"> Per damage Deductible: \$100 	
<p>Trip Interruption</p> <ul style="list-style-type: none"> Maximum Limit: \$10,000 	100%	100%