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 and Coinsurance do not apply to the Deductible.
Copayments do not apply to the Out-of-Pocket Maximum.

	In-Network	Out-of-Network	Outside the USA
Deductible per Injury or Illness	$250	$750	$250
Coinsurance	Plan pays 80% Insured Person pays 20%	Plan pays 50% Insured Person pays 50%	Plan pays 100% Insured Person pays 0%
Out-of-Pocket Maximum	$1,500	$3,000	Unlimited
Acute Onset of Pre-Existing Conditions	Eligible Medical Expenses are subject to Deductible and Coinsurance amounts and limited to Usual, Reasonable and Customary Charges per Policy Period up to the Maximum Limit per Illness and may be subject to a Maximum Benefit 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	Outside the USA
Preventative Care • Maximum Limit: $500 • Routine Physical Examinations and routine inoculations / vaccinations	100%	Not covered	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	Outside the USA
Physician / Specialist Visit **Maximum Visits per day: 1** (unless visit is for a different medical/surgical specialty)	80%	50%	100%
Teladoc Consultation • 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. 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.	100%	N/A	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	Outside the USA
Urgent Care Clinic • Not subject to Deductible • Copayment: $25	80%	50%	100%
Walk-in Clinic • Not subject to Deductible • Copayment: $25	80%	50%	100%
Hospital Emergency Room Injury: Not subject to Emergency Room Deductible but subject to plan Deductible Illness: Subject to the plan Deductible and an additional $350 Deductible for each Emergency Room visit. $350 Deductible will be waived if admitted to the Hospital.	80%	50%	100%
Pre-admission Testing	80%	50%	100%
Hospitalization / Room & Board* • Average semi-private room rate • Includes nursing, miscellaneous and Ancillary Services	80%	50%	100%
Intensive Care*	80%	50%	100%
Outpatient Surgical / Hospital Facility*	80%	50%	100%
Laboratory	80%	50%	100%
Radiology / X-ray	80%	50%	100%
Advance Diagnostics	80%	50%	100%
Surgery*	80%	50%	100%
Reconstructive Surgery* • Surgery is incidental to or follows Surgery that was covered under the plan	80%	50%	100%
Assistant Surgeon • 20% of the primary surgeon's eligible fee	80%	50%	100%
Chemotherapy / Radiation Therapy*	80%	50%	100%
Inpatient Mental or Nervous Disorder* • Maximum days: 45 • Maximum Limit: $10,000	50%	50%	50%
Outpatient Mental or Nervous Disorder • Maximum Limit: $500	80%	80%	80%
Chiropractic Care • Maximum per day: $25 • Maximum Limit: 10 visits • Treatment plan required	80%	50%	100%
Physical Therapy • Maximum Visits per day: 1 • Maximum Limit: 15 visits and 2 modalities per visit • Treatment plan required	80%	50%	100%
Extended Care Facility* • Upon direct transfer from Hospital	80%	50%	100%
Home Nursing Care* • Maximum days: 15 • Provided by a Home Health Care Agency • Upon direct transfer from Hospital	80%	50%	100%
Durable Medical Equipment	80%	50%	100%

* 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	Outside the USA
Prescriptions • Dispensing Maximum: 90 days per prescription for an Injury or Illness	80%	80%	100%

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	Outside the USA
Emergency Local Ambulance • Subject to Deductible and Coinsurance • Covered for Injury • Covered for Illness only if admitted to Hospital	80%	50%	100%
Emergency Medical Evacuation* • 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%	100%
Bedside Visit • 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.	80%	50%	100%
Interfacility Ambulance Transfer* • Transfer must be a result of an Inpatient Hospital admission	100%	100%	100%
Natural Disaster Evacuation* • Maximum Limit: $25,000 • Approved in advance by the Plan Administrator	100%	100%	100%
Return of Minor Children* • Maximum Limit: $100,000 • Approved in advance by the Plan Administrator	100%	100%	100%
Return of Mortal Remains* • 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%	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	Outside the USA
Accidental Death & Dismemberment • Principal Sum Maximum: $50,000 • Death must occur within 90 days of the Accident	**Accidental Death: 100% of Principal Sum Accidental Dismemberment:** Loss Percent of Principal Sum Sight of 1 eye 50% 1 hand or 1 foot 50% 1 hand and loss of sight of 1 eye 100% 1 foot and loss of sight of 1 eye 100% 1 hand and 1 foot 100% Both hands or both feet 100% Sight of both eyes 100%		
Traumatic Dental Injury • 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%	80%	50%	100%
Emergency Eye Examination • Subject to Coinsurance • Deductible per occurrence: $50 (plan Deductible waived) • Maximum Limit: $150 • Loss or damage to prescription corrective lenses due to an Accident	80%	50%	100%
Incidental Trip • Maximum days: 14 • Home Country is outside the United States	100%	100%	100%
Lost Luggage • Maximum Limit: $500 • Maximum Limit: $50 per item	100%	100%	100%
Natural Disaster • Limit per day: $250 • Maximum days: 5	100%	100%	100%
Personal Liability • 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.	Combined Maximum Limit: $25,000 Injury to third person: • Per Injury Deductible: $100 Damage to third person's property: • Per damage Deductible: $100		
Trip Interruption • Maximum Limit: $10,000	100%	100%	100%