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LA VIE À L'ÈTRANGER

Schedule of Benefits

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LA VIE À L'ÈTRANGER

PRESTIGE 2500

Schedule of Benefits

WellAway®

Sécurité Sociale Caisse des Français de l'Étranger

PRESTIGE 2500

SCHEDULE OF BENEFITS

LIMIT & COST SHARING

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Annual limit	Unlimited	Unlimited	Unlimited	Unlimited
Deductible	$2,500 individual $5,000 family	$2,500 individual $5,000 family	$2,500 individual $5,000 family	$5,000 individual $10,000 family
Out-of-pocket maximum	$0	$5,000 individual $10,000 family	$5,000 individual $10,000 family	$10,000 individual $20,000 family

INPATIENT CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Hospitalization	Deductible	Deductible	Deductible	Out of network deductible
Rehabilitative services	Deductible	Deductible	Deductible	Out of network deductible
Physician services	Deductible	Deductible	Deductible	Out of network deductible
Psychiatric hospitalization	Deductible	Deductible	Deductible	Out of network deductible
Emergency medical transportation	$105 copay	$105 copay	$205 copay	Out of network deductible

WELLNESS CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Routine medical exam	100%	100%	100%	Not covered
Cancer screening	100%	100%	100%	Not covered
Cryotherapy	100%	100%	100%	Not covered

PRESCRIPTION DRUGS

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Preventive	100%	100%	100%	Not covered
Generic	100%	$10 copay	$10 copay	Not covered
Brand	100%	$25 copay	$25 copay	Not covered
Non-preferred brands	100%	$55 copay	$55 copay	Not covered
Specialty	100%	$105 copay	$105 copay	Not covered

All benefits with 100% coverage are payable up to the policy limit.
All coverages are in US Dollar amounts.

PRESTIGE 2500
SCHEDULE OF BENEFITS

MATERNITY CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Prenatal and postnatal consultations	100%	$60 copay	Deductible	Out of network deductible
Labor and delivery - hospital stay	100%	$260 copay	Deductible	Out of network deductible
Birthing center	100%	$305 copay	$405 copay	Out of network deductible
Newborn care	100%	$110 copay	Deductible	Out of network deductible
Congenital anomaly	100%	$260 copay	Deductible	Out of network deductible
Infertility treatment	Not covered	Not covered	Not covered	Not covered
Sterilization	100%	100%	Deductible	Out of network deductible

OUTPATIENT CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Urgent care center	100%	$55 copay	$75 copay	Out of network deductible
Emergency room	100%	$255 copay	$305 copay	Out of network deductible
Outpatient hospital facility & surgical care	100%	$255 copay	Deductible	Out of network deductible
Skilled nursing facility	100%	$150 copay ($765 limit)	$260 copay ($765 limit)	Out of network deductible
General consultation / primary care visit	100%	$25 copay	$55 copay	Out of network deductible
Specialist consultation	100%	$45 copay	$75 copay	Out of network deductible
Psychiatric consultation	100%	$45 copay	$75 copay	Out of network deductible
Laboratory tests	100%	$55 copay	$105 copay	Out of network deductible
Basic radiology	100%	$55 copay	$105 copay	Out of network deductible
Advanced radiology	100%	$105 copay	$205 copay	Out of network deductible
Durable medical equipment	100%	$105 copay	Deductible	Out of network deductible
Rehabilitation and habilitation services	100%	$35 copay	$65 copay	Out of network deductible
Physical & speech therapy, spinal manipulation	100%	$35 copay	Deductible	Out of network deductible
Cancer treatment, drugs & reconstructive surgery	100%	Deductible	Deductible	Out of network deductible
Dialysis	100%	$305 copay	$405 copay	Out of network deductible

All benefits with 100% coverage are payable up to the policy limit.
All coverages are in US Dollar amounts.

PRESTIGE 2500

SCHEDULE OF BENEFITS

EVACUATION & REPATRIATION

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Medical evacuation	Paid in full up to $120,000 limit per covered person, per benefit period			
Medical repatriation	Paid in full up to $50,000 lifetime limit per covered person			
Repatriation of mortal remains	Paid in full up to $25,000 lifetime limit per covered person			

CHILD WELLNESS CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Routine child exams & immunizations	100%	100%	100%	Out of network deductible
Annual routine tests	100%	100%	100%	Out of network deductible
Routine dental exams for children under 19	100%	100%	100%	Out of network deductible
Eye exams for children under 19	100%	100%	100%	Out of network deductible
Eye glasses for children under 19	100%	100%	100%	Out of network deductible

DENTAL & VISION COVERAGE (OPTIONAL)

Dental & vision benefits are offered a package and may not be purchased separately.

Maximum benefit	$3,500 per policy year
Deductible	$100 lifetime

	FIRST YEAR	SECOND YEAR	THIRD YEAR
Basic (routine)	65%	80%	90%
Major restorative	25%	50%	65%
Preventive (exams & cleanings, 2 per year)	100%	100%	100%
Orthodontic treatment (covered for children under the age of 19 - $1,200 lifetime maximum per child, $600 annual limit)	10%	25%	50%

Vision care

(vision subject to 6 month waiting period)

Routine vision exam (one vision exam per year - includes any fees for contact lens fittings)	**$75** $10 copay
Lenses (single vision, bifocal, trifocal)	Paid in full up to $200 (limited to one every 24 months)
Frames (limited to one per policy year)	Paid in full up to $225
Contact lenses (in lieu of frames)	Paid in full up to $225

All benefits with 100% coverage are payable up to the policy limit.
All coverages are in US Dollar amounts.

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LA VIE À L'ÈTRANGER

PREMIER 4500

Schedule of Benefits

WellAway®

Sécurité Sociale Caisse des Français de l'Étranger

PREMIER 4500
SCHEDULE OF BENEFITS

LIMIT & COST SHARING

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Annual limit	Unlimited	Unlimited	Unlimited	Unlimited
Deductible	$4,500 individual $9,000 family	$4,500 individual $9,000 family	$4,500 individual $9,000 family	$9,000 individual $18,000 family
Out-of-pocket maximum	$0	$7,150 individual $14,300 family	$7,150 individual $14,300 family	$14,300 individual $28,600 family

INPATIENT CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Hospitalization	100%	Deductible	Deductible	Out of network deductible
Rehabilitative services	100%	Deductible	Deductible	Out of network deductible
Physician services	100%	Deductible	Deductible	Out of network deductible
Psychiatric hospitalization	100%	Deductible	Deductible	Out of network deductible
Emergency medical transportation	$110 copay	$110 copay	$210 copay	Out of network deductible

WELLNESS CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Routine medical exam	100%	100%	100%	Not covered
Cancer screening	100%	100%	100%	Not covered
Cryotherapy	100%	100%	100%	Not covered

PRESCRIPTION DRUGS

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Preventive	100%	100%	100%	Not covered
Generic	100%	$15 copay	$15 copay	Not covered
Brand	100%	$30 copay	$30 copay	Not covered
Non-preferred brands	100%	$60 copay	$60 copay	Not covered
Specialty	100%	$110 copay	$110 copay	Not covered

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PREMIER 4500
SCHEDULE OF BENEFITS

MATERNITY CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Prenatal and postnatal consultations	100%	$65 copay	Deductible	Out of network deductible
Labor and delivery - hospital stay	100%	$310 copay	Deductible	Out of network deductible
Birthing center	100%	$310 copay	$310 copay	Out of network deductible
Newborn care	100%	$120 copay	Deductible	Out of network deductible
Congenital anomaly	100%	$260 copay	Deductible	Out of network deductible
Infertility treatment	Not covered	Not covered	Not covered	Not covered
Sterilization	100%	100%	Deductible	Out of network deductible

OUTPATIENT CARE

	WORLDWIDE	SELECT NETWORK	IN-NETWORK	OUT OF NETWORK
Urgent care center	100%	$60 copay	$80 copay	Out of network deductible
Emergency room	100%	$260 copay	$360 copay	Out of network deductible
Outpatient hospital facility & surgical care	100%	$260 copay	Deductible	Out of network deductible
Skilled nursing facility	100%	$175 copay ($765 limit)	$260 copay ($780 limit)	Out of network deductible
General consultation / primary care visit	100%	$30 copay	$60 copay	Out of network deductible
Specialist consultation	100%	$50 copay	$80 copay	Out of network deductible
Psychiatric consultation	100%	$50 copay	$80 copay	Out of network deductible
Laboratory tests	100%	$60 copay	$110 copay	Out of network deductible
Basic radiology	100%	$60 copay	$110 copay	Out of network deductible
Advanced radiology	100%	$110 copay	$210 copay	Out of network deductible
Durable medical equipment	100%	$110 copay	Deductible	Out of network deductible
Rehabilitation and habilitation services	100%	$35 copay	$40 copay	Out of network deductible
Physical & speech therapy, spinal manipulation	100%	$35 copay	Deductible	Out of network deductible
Cancer treatment, drugs & reconstructive surgery	100%	Deductible	Deductible	Out of network deductible
Dialysis	100%	$305 copay	$410 copay	Out of network deductible

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PREMIER 4500
SCHEDULE OF BENEFITS

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Routine vision exam (one vision exam per year - includes any fees for contact lens fittings)	$75 $10 copay
Lenses (single vision, bifocal, trifocal)	Paid in full up to $200 (limited to one every 24 months)
Frames (limited to one per policy year)	Paid in full up to $225
Contact lenses (in lieu of frames)	Paid in full up to $225

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