



# LA VIE À L'ÉTRANGER

## PREMIER 4500

### Schedule of Benefits



# PREMIER 4500

## SCHEDULE OF BENEFITS

WORLDWIDE      SELECT NETWORK      IN-NETWORK      OUT OF NETWORK

### 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

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

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WORLDWIDE      SELECT NETWORK      IN-NETWORK      OUT OF NETWORK

### 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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### EVACUATION & REPATRIATION

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

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.

			FIRST YEAR	SECOND YEAR	THIRD YEAR
Maximum benefit	\$3,500 per policy year	Basic (routine)	65%	80%	90%
Deductible	\$100 lifetime	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

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