GeoBlue
International Health Insurance for Higher Education

geobluestudents.com

GeoBlue International Inbound K-12 Plan Renewal

The MacDuffie School

July 1, 2023

GeoBlue, 933 First Avenue, King of Prussia, PA 19406
1.855.682.7965 | 1.610.254.5300 | fax 1.610.482.9953

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Medical Expense Benefits Bronze

SCHEDULE OF BENEFITS - TABLE 1

Limits – Individual Insured	
MEDICAL EXPENSES	
Coverage Year Limit	$250,000
Coverage Year Deductible	$300 per Coverage Year
Coverage Year Out-of-Pocket Limit The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services, subject to the limits and provisions of this Certificate	After the Covered Person reaches a $5,000 Out-of-pocket Limit per Coverage Year, the Insurer pays the Allowed Amount at 100% and up to the applicable maximums in the Tables 2 and 3.
EMERGENCY TRANSPORTATION SERVICES	
Emergency Medical Evacuation	100% of the Actual Cost
Emergency Family Travel Arrangements	Maximum Benefit up to $1,000 per Coverage Year
Repatriation of Mortal Remains	100% of the Actual Cost
OTHER COVERAGES	
Accidental Death & Dismemberment	Maximum Benefit: Principal Sum up to $10,000

SCHEDULE OF BENEFITS - TABLE 2
MEDICAL EXPENSE BENEFITS

MEDICAL EXPENSES	Participating Provider+	Non-Participating Provider
Physician Office Visits	After the Deductible is satisfied, 80% of the Allowed Amount	After the Deductible is satisfied, 60% of the Allowed Amount
Treatment at an Urgent Care Facility	After the Deductible is satisfied, 80% of the Allowed Amount	After the Deductible is satisfied, 60% of the Allowed Amount
Hospital and Physician Outpatient Services	After the Deductible is satisfied, 80% of the Allowed Amount	After the Deductible is satisfied, 60% of the Allowed Amount
Inpatient Hospital Services	After the Deductible is satisfied, 80% of the Allowed Amount	After the Deductible is satisfied, 60% of the Allowed Amount
Emergency Hospital Services	After the Deductible is satisfied, 80% of the Allowed Amount	After the Deductible is satisfied, 60% of the Allowed Amount

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SCHEDULE OF BENEFITS - TABLE 3
MEDICAL EXPENSE BENEFITS

The benefits listed below are subject to coverage maximums, Deductible, Coinsurance, and Copayments listed in Tables 1 & 2 above.

MEDICAL EXPENSES	Covered Person
Routine Preventive Care Services	Allowed Amount
Vaccinations as required by the Member	Allowed Amount
Routine testing/screening for Tuberculosis	Allowed Amount
Inpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount up to $10,000 Maximum per Coverage Year
Outpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount up to $5,000 Maximum per Coverage Year
Outpatient back and spine treatment (including modalities)	Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis
Treatment of specified therapies, including acupuncture and Physiotherapy	Allowed Amount up to 40 visits per Coverage Year on an Outpatient basis
Complications of Pregnancy	Allowed Amount
Professional ground service to nearest hospital	Allowed Amount up to $1,000 per Injury or Sickness.
Medical treatment arising from participation in interscholastic sports	Allowed Amount up to $15,000 per Injury or Sickness. Injuries from participation in intramural sports are covered the same as any other injury
Repairs to sound, natural teeth required due to an Injury	Allowed Amount up to $500 per Coverage Year maximum
Medical treatment received in the Home Country, if NOT covered by Other Certificate	Allowed Amount up to $1,000 per Coverage year maximum
Outpatient prescription drugs including oral contraceptives and devices	Prescription Drug Program with the Copayment stated below, up to a maximum of $2,000 per Coverage Year. Limited to a 31-day supply for initial fill or refill
1. Generic Drugs	All except a $10 Copayment per prescription
2. Brand Name Drugs	All except a $25 Copayment per prescription

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Medical Expense Benefits Silver

SCHEDULE OF BENEFITS - TABLE 1

Limits – Individual Insured	
MEDICAL EXPENSES	
Coverage Year Limit	$250,000
Coverage Year Deductible	$100 per Coverage Year
EMERGENCY TRANSPORTATION SERVICES	
Emergency Medical Evacuation	100% of the Actual Cost
Emergency Family Travel Arrangements	Maximum Benefit up to $1,000 per Coverage Year
Repatriation of Mortal Remains	100% of the Actual Cost
OTHER COVERAGES	
Accidental Death & Dismemberment	Maximum Benefit: Principal Sum up to $10,000

SCHEDULE OF BENEFITS - TABLE 2
MEDICAL EXPENSE BENEFITS

MEDICAL EXPENSES	Participating Provider+	Non-Participating Provider
Physician Office Visits	After the Deductible is satisfied, 100% of the Allowed Amount after a $25 Copayment per visit.	After the Deductible is satisfied, 80% of the Allowed Amount after a $25 Copayment per visit.
Treatment at an Urgent Care Facility	After the Deductible is satisfied,100% of the Allowed Amount	After the Deductible is satisfied, 80% of the Allowed Amount
Hospital and Physician Outpatient Services	After the Deductible is satisfied, 100% of the Allowed Amount	After the Deductible is satisfied, 80% of the Allowed Amount
Inpatient Hospital Services	After the Deductible is satisfied, 100% of the Allowed Amount	After the Deductible is satisfied, 80% of the Allowed Amount
Emergency Hospital Services	After the Deductible is satisfied, 100% of the Allowed Amount after a $75 Copayment per visit. If admitted to Hospital, then 100% of Copayment Waived.	After the Deductible is satisfied, 80% of the Allowed Amount. after a $75 Copayment per visit. If admitted to Hospital, then 100% of Copayment Waived.

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SCHEDULE OF BENEFITS - TABLE 3
MEDICAL EXPENSE BENEFITS

The benefits listed below are subject to coverage maximums, Deductible, Coinsurance, and Copayments listed in Tables 1 & 2 above.

MEDICAL EXPENSES	Covered Person
Routine Preventive Care Services	Allowed Amount
Vaccinations as required by the Member	Allowed Amount
Routine testing/screening for Tuberculosis	Allowed Amount
Inpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount up to $10,000 Maximum per Coverage Year
Outpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount up to $5,000 Maximum per Coverage Year
Outpatient back and spine treatment (including modalities)	Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis
Treatment of specified therapies, including acupuncture and Physiotherapy	Allowed Amount up to 40 visits per Coverage Year on an Outpatient basis
Complications of Pregnancy	Allowed Amount
Professional ground service to nearest hospital	Allowed Amount up to $1,000 per Injury or Sickness.
Medical treatment arising from participation in interscholastic sports	Allowed Amount up to $15,000 per Injury or Sickness. Injuries from participation in intramural sports are covered the same as any other injury
Repairs to sound, natural teeth required due to an Injury	Allowed Amount up to $500 per Coverage Year maximum
Medical treatment received in the Home Country, if NOT covered by Other Certificate	Allowed Amount up to $1,000 per Coverage year maximum
Outpatient prescription drugs including oral contraceptives and devices	Prescription Drug Program with the Copayment stated below, up to a maximum of $2,000 per Coverage Year. Limited to a 31-day supply for initial fill or refill
1. Generic Drugs	All except a $10 Copayment per prescription
2. Brand Name Drugs	All except a $25 Copayment per prescription

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Medical Expense Benefits Gold

SCHEDULE OF BENEFITS - TABLE 1

Limits – Individual Insured	
MEDICAL EXPENSES	
Coverage Year Limit	$300,000
Coverage Year Deductible	$0 per Coverage Year
EMERGENCY TRANSPORTATION SERVICES	
Emergency Medical Evacuation	100% of the Actual Cost
Emergency Family Travel Arrangements	Maximum Benefit up to $1,000 per Coverage Year
Repatriation of Mortal Remains	100% of the Actual Cost
OTHER COVERAGES	
Accidental Death & Dismemberment	Maximum Benefit: Principal Sum up to $10,000

SCHEDULE OF BENEFITS - TABLE 2
MEDICAL EXPENSE BENEFITS

MEDICAL EXPENSES	Participating Provider+	Non-Participating Provider
Physician Office Visits	100% of the Allowed Amount	80% of the Allowed Amount
Treatment at an Urgent Care Facility	100% of the Allowed Amount	80% of the Allowed Amount
Hospital and Physician Outpatient Services	100% of the Allowed Amount	80% of the Allowed Amount
Inpatient Hospital Services	100% of the Allowed Amount	80% of the Allowed Amount
Emergency Hospital Services	100% of the Allowed Amount	80% of the Allowed Amount.

SCHEDULE OF BENEFITS - TABLE 3
MEDICAL EXPENSE BENEFITS

The benefits listed below are subject to coverage maximums, Deductible, Coinsurance, and Copayments listed in Tables 1 & 2 above.

MEDICAL EXPENSES	Covered Person
Routine Preventive Care Services	Allowed Amount
Vaccinations as required by the Member	Allowed Amount
Routine testing/screening for Tuberculosis	Allowed Amount
Inpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount up to $10,000 Maximum per Coverage Year
Outpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount up to $5,000 Maximum per Coverage Year
Outpatient back and spine treatment (including modalities)	Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis
Treatment of specified therapies, including acupuncture and Physiotherapy	Allowed Amount up to 40 visits per Coverage Year on an Outpatient basis
Complications of Pregnancy	Allowed Amount

MEDICAL EXPENSES	Covered Person
Professional ground service to nearest hospital	Allowed Amount up to $1,000 per Injury or Sickness.
Medical treatment arising from participation in interscholastic sports	Allowed Amount up to $15,000 per Injury or Sickness. Injuries from participation in intramural sports are covered the same as any other injury
Repairs to sound, natural teeth required due to an Injury	Allowed Amount up to $500 per Coverage Year maximum
Medical treatment received in the Home Country, if NOT covered by Other Certificate	Allowed Amount up to $1,000 per Coverage year maximum
Outpatient prescription drugs including oral contraceptives and devices	Prescription Drug Program with the Copayment stated below, up to a maximum of $2,000 per Coverage Year. Limited to a 31-day supply for initial fill or refill
1. Generic Drugs	All except a $10 Copayment per prescription
2. Brand Name Drugs	All except a $25 Copayment per prescription