Welcome to GeoBlue®

Simplifying the international healthcare experience to keep you safe and healthy throughout your journey

CSU Long Beach
2024-2025

WELCOME

TO YOUR INSTITUTION'S HEALTH PLAN

Embarking on a study abroad program is an exciting venture that gives students, faculty and staff a broader, more global view of the world. Your GeoBlue health insurance plan provides you access to global medical expertise with responsive, multi-channel service. Register on the GeoBlue mobile app or online through the Member Hub to learn about the extra care you receive when you travel with GeoBlue.

INTRODUCTION TO YOUR HEALTH PLAN

Important plan information and health tools

ACCESSING CARE

How to receive care throughout your journey

SELF-SERVICE TOOLS

Convenient tools available on the GeoBlue mobile app and Member Hub

SUBMITTING A CLAIM

File a claim for reimbursement

REVIEWING PLAN BENEFITS

What is covered by your plan?

This pamphlet contains a brief summary of the features and benefits for insured participants covered under your school health insurance. This is not a contract of insurance. Coverage is provided under an insurance policy under which your school is a participating school. The policy is underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois policy form 54.1206 (CA)/28.1332 (NY). Complete information on the insurance is contained in the Certificate of Insurance which is on file with the school and is made available to all insured participants. If there is a difference between this program description and the certificate wording, the certificate controls.

GLOSSARY

of Important Terms and Phrases

Balance Billing: When a provider bills you for the difference between the provider's charge and the amount your health insurance plan pays. Your normal deductible and coinsurance are not counted as balance billing.

Coinsurance: The percentage of your healthcare costs that is not paid by the health insurance plan. Therefore, it's the percentage of the cost you are responsible for.

Coinsurance Maximum: The maximum amount of coinsurance a member pays during the policy year for covered expenses. Limitations may apply.

Copay or Copayment: The specific dollar amount you will pay at the time of service.

Claim: Documentation submitted for payment from a provider or you for medical services rendered.

Certificate of Coverage: It describes the benefit plan with specific conditions in which you and all eligible dependents have been enrolled (explains medical, dental, and vision coverage).

Coverage Period: The length of time that you are covered under a specific policy.

Deductible: An amount you are responsible to pay for eligible expenses before the health insurance plan begins to pay.

Explanation of Benefits (EOB): An EOB is not a bill, but a summary of how your claims were processed and what you may owe. Your healthcare professional may bill you directly for the remainder of what you owe.

Prescription (RX): An instruction written by a medical practitioner that authorizes you to be provided a medicine or treatment.

Performing Provider: The individual or group licensed to perform medical care that provided medical services to you.

Primary Care Physician (PCP): A physician who provides both the first contact for you with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

Premium: The specific amount of money you have to pay to the health insurance company each month in exchange for the health insurance company paying a portion of your healthcare costs.

Outpatient: When you receive care at a medical facility but are not admitted to the facility overnight or are at the facility for 24 hours or less.

Out-of-Network Provider: A medical provider who is not contracted with Blue Cross Blue Shield companies. This typically results in a higher coinsurance and may result in additional costs to you.

Out-of-Pocket Maximum: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount.

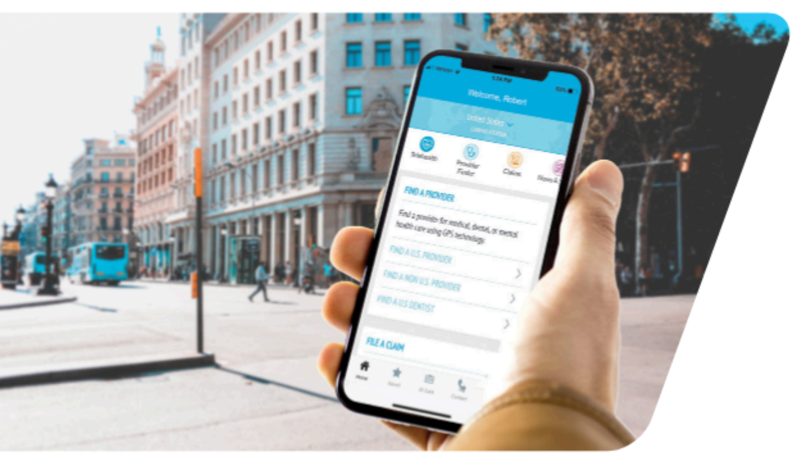
Network: The facilities, providers, and suppliers your health insurance company contracts with to provide services at discounted rates. The network you would utilize is Blue Cross Blue Shield companies.

Medical Evacuation: The insurer will pay the medically necessary expenses incurred for you if you become ill or injured while traveling outside your home country for transportation to the closest location of adequate care. May also be referred to as "Medical Repatriation."

Inpatient: When you receive care at a medical facility and are admitted overnight, or are at the facility for more than 24 hours.

INTRODUCTION TO YOUR HEALTH PLAN

IMPORTANT PLAN INFORMATION AND HEALTH TOOLS



Get your GeoBlue ID card

It is important to have your ID card available when receiving healthcare services. Your card can be accessed from multiple sources:

- You can obtain an electronic version of your ID card on the GeoBlue mobile app and Member Hub
- You can request a replacement ID card through the mobile app and Member Hub. You can also contact customer service for assistance in requesting a replacement ID card

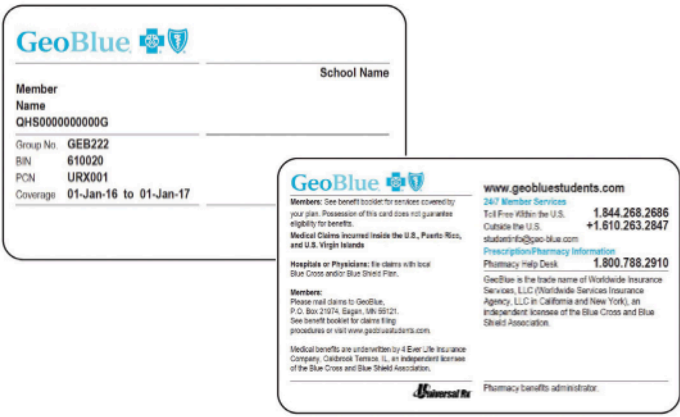
When you receive your ID card, please check the information for accuracy. Contact customer service if you find any errors.

Register on the GeoBlue mobile app or Member Hub to access important plan information

- Submit and track your claims
- Obtain electronic ID card
- Locate Blue Cross® Blue Shield® providers and hospitals within the U.S.
- Access global health and safety tools including medical translations, drug equivalents and news and safety information

To register, download the GeoBlue mobile app from the Apple or Google Play app stores or visit the Member Hub on www.geobluestudents.com. After you register you can use your log in information for both the website and app.

Your ID card



ID card images for illustration purposes only

We're available to assist 24/7/365

PHONE
1-844-268-2686

Email
Use the contact form on the GeoBlue mobile app and Member Hub

ACCESSING CARE

FIND HEALTHCARE WITHIN THE U.S.

Student Health Center

Student health centers are a convenient healthcare option for basic health services. Consult your school's resources for more specific information about the care available to you, location(s) and hours. If you choose to receive care from your student health center, copayments, coinsurance and/or deductibles may be waived.

Find a Provider

You have access to the leading Blue Cross Blue Shield network within the U.S., Puerto Rico and U.S. Virgin Islands. To find a doctor or facility, select **"Provider Finder"** in the GeoBlue mobile app or visit the **"Doctor and Facilities Finder"** section then select **"U.S. Provider Finder"** in the Member Hub on www.geobluestudents.com.

Scheduling an Appointment with a Blue Cross Blue Shield Provider

Once you select a provider, call to confirm they are in network and schedule your appointment. You will need to keep your GeoBlue ID card handy when scheduling. If you need assistance with scheduling an appointment, submit a **"Service Request"** from the Tools & Services section on the Member Hub on www.geobluestudents.com.

At the time of service, you will need to show the provider your ID card to confirm you are covered by Blue Cross Blue Shield. Depending on your coverage, you may be responsible for a copayment, coinsurance and/or deductible before a service is completed.

Global TeleMD™

We know it's important to get the healthcare you need, when you need it. We've teamed up with Teladoc Health to bring you Global TeleMD, a telemedicine service that provides unlimited, 24/7/365 access to free doctor consultations by telephone or video. Doctors are available worldwide. Prescriptions may also be provided, as appropriate (subject to local regulations). To access Global TeleMD, download the Global TeleMD app or select **"Telehealth"** then **"Talk to a Doctor"** in the GeoBlue mobile app.

Out-of-Network Providers

If you receive care from an out-of-network provider, you may need to pay out of pocket and submit a claim for reimbursement. Click **"How to File a Claim"** in the Member Hub on www.geobluestudents.com to download the appropriate claim form. You can submit claims electronically using the GeoBlue mobile app or the Member Hub.

Prescription Benefits

Present your ID card at any participating pharmacy, and you will be charged in accordance with your plan benefits.*

**Certain limitations and exclusions apply to your coverage under this plan and may affect your coverage. Your Certificate of Coverage is on file with your institution and in the Member Hub on www.geobluestudents.com.*

DEDICATED WELLNESS SUPPORT

GLOBAL WELLNESS ASSIST AVAILABLE 24/7/365

We offer a variety of emotional, practical and physical support services for you helping to make transitions more comfortable and assignments more successful.

Emotional Support

- ✓ 24/7/365 clinical intake, message and referral service
- ✓ Harmony between academic and personal life
- ✓ Managing anxiety, depression, stress and overall life changes
- ✓ Surviving the loss of a loved one

Practical Support

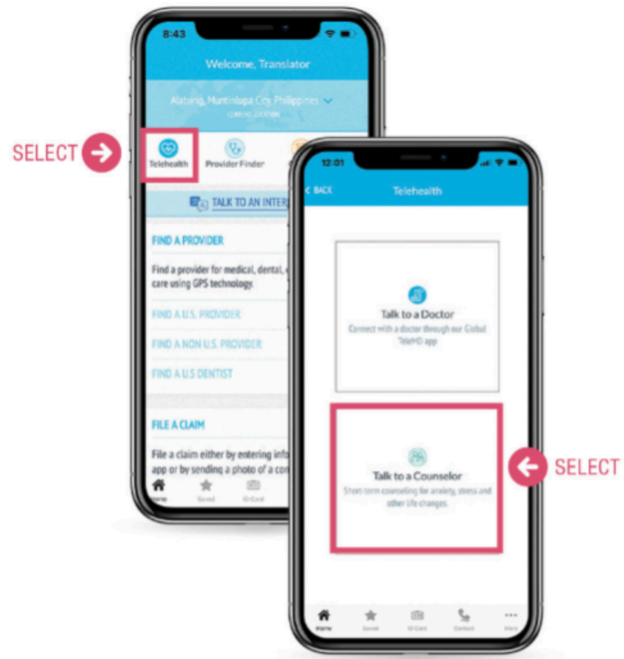
- ✓ Unlimited telephonic financial assistance from financial professionals
- ✓ Telephonic or in-person legal assistance and consultation with attorneys
- ✓ Managing academic or workplace pressure

Physical Support

- ✓ Wellness coaching and support for wellness initiatives, including weight loss, fitness, nutrition, stress management and overall lifestyle improvement
- ✓ Health risk assessment to obtain and assess individual and aggregate health data
- ✓ Support in finding assistance with substance use

Global Wellness Assist

Global Wellness Assist is an international employee assistance program (EAP) for students, faculty and staff traveling globally on behalf of an institution, providing access to six free confidential solution-focused counseling sessions. Professionals are ready to assist with any issue, anytime, any day.



To access Global Wellness Assist's services, download the GeoBlue mobile app or visit the "Wellness" section in the Member Hub on www.geobluestudents.com.

SELF-SERVICE TOOLS

Our digital tools put access to global healthcare right in your hands! There is a wide range of information available to you on the GeoBlue mobile app or Member Hub, including:

Claim Submission and Status

Submit and track the status of your claims.

ID Card

Obtain an electronic copy of your ID card and request replacements.

Telehealth

Talk to a doctor through Global TeleMD and/or talk to a counselor through Global Wellness Assist—both services are free, and you do not need to leave your home.

Provider Directory

Review profiles of preferred doctors and hospitals to find the best match, view their contact details and locate the office.

Medical Term Translations

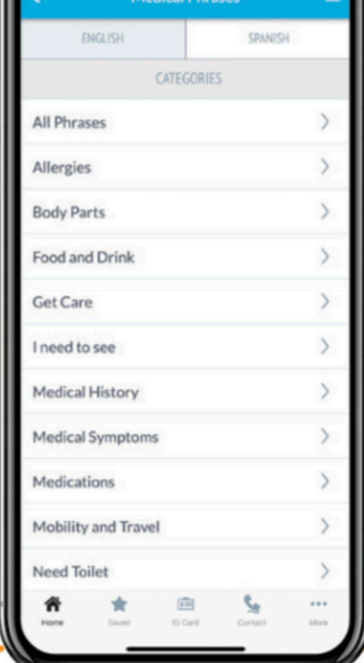
USe the translation tool for common healthcare terms and phrases.

Medicine Equivalent Tool

Find country-specific equivalents for prescription and over-the-counter medications.

News and Safety Information

Receive push notifications and alerts detailing the latest security and health issues based on your location. You can also view country or city profiles on crime, terrorism and natural disasters.



Download the app today!

Register on the GeoBlue mobile app or online through the Member Hub. Once registered the login information will be the same whether using the app or online.

CLAIM SUBMISSION

IF YOU NEED TO SUBMIT A CLAIM FOR REIMBURSEMENT, YOU HAVE THE FOLLOWING OPTIONS:

eClaims

The quickest most convenient way to submit your claims is through the GeoBlue mobile app or Member Hub. Under **"Claims"** you can chose to submit a claim through **"File an eClaim"** or **"View My Claims"** to see saved claims.

Email and Fax

If you prefer to submit a claim via email or fax, a printable claim form and detailed instructions are available in the Member Hub on www.geobluestudents.com.

Visit the **"How to File a Claim"** section of the Member Hub and click **"How do you file a claim with GeoBlue?"** to download the appropriate claim form.

Email: claims@geo-blue.com
Fax: 1-610-482-9623

Postal Mail

If you prefer to submit a claim via postal mail, a printable claim form and detailed instructions are available in the Member Hub on www.geobluestudents.com.

Visit the **"How to File a Claim"** section of the Member Hub and click **"How do you file a claim with GeoBlue?"** to download the appropriate claim form.

Mail to: GeoBlue, P.O. Box 21974
Eagan, MN 55121

Follow these tips to speed up the claims reimbursement process:

- ✓ If you mail or fax your claim(s) make sure your claim form is filled out completely, and don't forget to sign it.
- ✓ Fill out a separate form for each doctor or office visit.
- ✓ Be sure to add a diagnosis or reason for treatment.
- ✓ Provide a detailed description and amount charged for each service.
- ✓ Clearly state how you'd like to be reimbursed.
- ✓ Make and keep handy copies of your bills, receipts and claim forms.

Missing information on the claim form or supporting documentation may delay your claim reimbursement.

Need to check the status of your claim?

No problem! Simply choose **"Claims"** in the GeoBlue app or visit the **"Claims"** section of the Member Hub. If you are using the mobile app, you can elect to receive a push notification when your claim is processed. For more help, visit the **"Claims"** section of the Member Hub.

REVIEWING PLAN BENEFITS

Benefit Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays	90%	50% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	150% of Medicare Rates
Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or a percentage of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance.		
Policy Year Deductible		
Individual	$150	$150
Combined Medical/Pharmacy Policy Year Deductible	Yes	Yes
Out-of-Pocket Maximum		
Individual	$6,850	$6,850
Physician's Services		
Physician's Office Visit - Primary Care Physician	100%, No Deductible, $25 copay	50% after plan deductible
Office Visit – Specialist	100%, No Deductible, $25 copay	50% after plan deductible
Surgery Performed In the Physician's Office	90% after plan deductible	50% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	100%, No Deductible, $25 copay	50% after plan deductible
Allergy Treatment/Injections	100%, No Deductible, $25 copay	50% after plan deductible
Preventive Care		
Routine Preventive Care – all ages	100% not subject to plan deductible or copayments	50% after plan deductible
Immunizations – all ages	100% not subject to plan deductible or copayments	50% after plan deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to plan deductible or copayments	50% after plan deductible
Lead Poisoning Screening Tests For Children under age 6	100% not subject to plan deductible or copayments	50% after plan deductible
Inpatient Hospital – Facility/Professional Charges		
Room and Board Charges	90% after plan deductible	50% after plan deductible

This pamphlet contains a brief summary of the features and benefits for insured participants covered under your school health insurance. This is not a contract of insurance. Coverage is provided under an insurance policy under which your school is a participating school. The policy is underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois policy form 54.1206 (CA)/28.1332 (NY). Complete information on the insurance is contained in the Certificate of Insurance which is on file with the school and is made available to all insured participants. If there is a difference between this program description and the certificate wording, the certificate controls.

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REVIEWING PLAN BENEFITS

Benefit Highlights	In-Network	Out-of-Network
Physician's Visits/Consultations	90% after plan deductible	50% after plan deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	90% after plan deductible	50% after plan deductible
Inpatient Services at Other Heath Care Facilities		
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Policy Year Maximum of 120 day limit.	90% after plan deductible	50% after plan deductible
Ambulatory Surgical Services		
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	90% after plan deductible	50% after plan deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	90% after plan deductible	50% after plan deductible
Emergency and Urgent Care Services		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Hospital Emergency Room	90% after plan deductible Additional $150 copay per visit – waived if admitted	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate. Additional $150 copay per visit – waived if admitted
Outpatient Professional Services (radiology, pathology and ER Physician)	90% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Urgent Care Facility	100%, No Deductible, $25 copay	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	90% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.

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REVIEWING PLAN BENEFITS

Benefit Highlights	In-Network	Out-of-Network
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	90% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Ambulance	90% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Independent X-ray and/or Lab Facility	90% after plan deductible	50% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Independent Facility	90% after plan deductible	50% after plan deductible
Maternity Care/Obstetrical Services		
Physician's Office visit to confirm pregnancy	100%, No Deductible, $25 copay	50% after plan deductible
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	90% after plan deductible	50% after plan deductible
Physician's Office visits in addition to the global maternity fee	100%, No Deductible, $25 copay	50% after plan deductible
Laboratory, Radiology Services and or Advance Radiological Imaging	90% after plan deductible	50% after plan deductible
Delivery Charges – Facility (Hospital, Birthing Center)	90% after plan deductible	50% after plan deductible
Termination of Pregnancy		
Medically Necessary	90% after plan deductible	50% after plan deductible
Elective	90% after plan deductible	50% after plan deductible

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REVIEWING PLAN BENEFITS

Benefit Highlights	In-Network	Out-of-Network
Infertility Expenses – Basic Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Physician's Services	90% after plan deductible	50% after plan deductible
Family Planning/Contraception Management See benefit description for specific coverages For Women		
Physician's Office Visit	100% not subject to plan deductible or copayments	50% after plan deductible
Inpatient Facility	100% not subject to plan deductible or copayments	50% after plan deductible
Outpatient Facility	100% not subject to plan deductible or copayments	50% after plan deductible
Physician's Services	100% not subject to plan deductible or copayments	50% after plan deductible
For Men		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Physician's Services	90% after plan deductible	50% after plan deductible
Obesity/Bariatric Surgery Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese.		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible

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REVIEWING PLAN BENEFITS

Benefit Highlights	In-Network	Out-of-Network
Physician's Services	90% after plan deductible	50% after plan deductible
Organ Transplant Services		
Includes all medically appropriate, non-experimental transplants.		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Physician's Services	90% after plan deductible	50% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	90% after plan deductible	Not Covered
Transgender Services		
See benefit description for covered services.		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Physician's Services	90% after plan deductible	50% after plan deductible
Nutritional Evaluation		
Policy Year Maximum of 3 visit limit. Limit does not apply to treatment of diabetes or for services due to a mental health or substance abuse diagnosis.		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Physician's Services	90% after plan deductible	50% after plan deductible
Nutritional Formulas	90% after plan deductible	50% after plan deductible
Acupuncture Physician's office visit	100%, No Deductible, $25 copay	50% after plan deductible
Chiropractic Care/Spinal Manipulations Physician's office visit	100%, No Deductible, $25 copay	50% after plan deductible
Telehealth	100%, No Deductible, $25 copay	50% after plan deductible

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REVIEWING PLAN BENEFITS

Benefit Highlights	In-Network	Out-of-Network
Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Limited Benefits – please see the benefit description for limitation on Dental Services due to an injury		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Physician's Services	90% after plan deductible	50% after plan deductible
TMJ Treatment	90% after plan deductible	50% after plan deductible
Diabetic Equipment	90% after plan deductible	50% after plan deductible
Durable Medical Equipment	90% after plan deductible	50% after plan deductible
External Prosthetic Appliances	90% after plan deductible	50% after plan deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Policy Year Maximum of $500	90% after plan deductible	50% after plan deductible
Mental Health		
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)	90% after plan deductible	50% after plan deductible
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Substance Abuse Health		
Inpatient Facility	90% after plan deductible	50% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)	90% after plan deductible	50% after plan deductible
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Outpatient Facility	90% after plan deductible	50% after plan deductible
Hearing Benefit One Examination per 24 month period	100%, No Deductible, $25 copay	50% after plan deductible

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REVIEWING PLAN BENEFITS

Benefit Highlights	In-Network	Out-of-Network
Hearing Aid Benefit Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 24 months	90% after plan deductible	50% after plan deductible
Home Health Care Services Policy Year Maximum of 120 visit limit	90% after plan deductible	50% after plan deductible
Private Duty Nursing Policy Year Maximum of 120 visit limit	90% after plan deductible	50% after plan deductible
Hospice Care Services	90% after plan deductible	50% after plan deductible
Infusion Therapy		
Outpatient Facility	90% after plan deductible	50% after plan deductible
Physician's Services	90% after plan deductible	50% after plan deductible
Short Term Rehabilitative Therapy		
Physician's Office Visit	100%, No Deductible, $25 copay	50% after plan deductible
Outpatient Hospital Facility	90% after plan deductible	50% after plan deductible

Prescription Drugs
Schedule of Benefits

The below section describes the coverage for Prescriptions Drugs for all Eligible Subscribers. The plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in the schedule and as described in the Prescription Drug Coverage section of this certificate. To receive Prescription Drug Benefits, the Eligible Subscriber may be required to pay a portion of the Covered Expenses. That portion includes any applicable Deductible and/or Copayments as may be applicable. Benefits are limited as described in the Prescription Drug section of this certificate and are subject to the Medical "Exclusions" section of this certificate.

Benefit Highlights	Participating Pharmacy	Non-Participating Pharmacy
Retail Prescription Drugs	Cost per 30 day Supply	Cost per 30 day Supply
Certain medications as part of preventive care services are covered at 100% with no cost sharing either through a retail drug store. Detailed information is available at www.healthcare.gov		
Tier 1 – Generic*	$10 copayment. Deductible does not apply	$10 copayment, after plan deductible.
Tier 2 – Formulary Brand-Name*	$25 copayment. Deductible does not apply	$25 copayment, after plan deductible.
Tier 3 – Non - Formulary	$50 copayment. Deductible does not apply	$50 copayment, after plan deductible.
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Exclusions and Expenses Not Covered

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REVIEWING PLAN BENEFITS

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Charges for preventive care, injuries or sickness incurred in your Home Country.
5. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with Urgent Care or an Emergency.
6. For or in connection with an Injury or Sickness which is due to participation in a riot, civil commotion or police action.
7. For claim payments that are illegal under applicable law.
8. Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
9. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Care or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
10. Non-Treatment Facilities, Institutions or Programs - Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations
11. For or in connection with experimental, investigational or unproven services.
    Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or
    - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this plan.
12. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
13. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty for cosmetic reasons; Redundant skin surgery; Removal of skin tags for cosmetic reasons; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
14. Services and supplies in connection with transgender services, except as specifically stated in the “Transgender Services” provision under the section COVERED EXPENSES BENEFIT DESCRIPTION.
15. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of COVERED EXPENSES BENEFIT DESCRIPTION. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
16. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
17. Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
18. Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
19. Infertility, Assisted Reproduction And Sterilization Reversal
    a. Treatment of infertility, including procedures, supplies and drugs;
    b. Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro

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fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof;

Please Note: This exclusion does not apply to the diagnosis of infertility or the surgical correction or a condition causing infertility. This would be treated the same as any other medical condition.

20. Reversal of male or female voluntary sterilization procedures.
21. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
22. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
23. Non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, gym or swim therapy, legal or financial counseling, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disabilities.
24. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
25. Family and marital counseling except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of an insured Subscriber.
26. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
27. Private duty nursing except as provided under the Home Health Services provision.
28. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
29. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and wigs other than for scalp hair prostheses worn due to alopecia areata or due to cancer treatment.
30. Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Schedule of Benefits section. A hearing aid is any device that amplifies sound.
31. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as shown in the Covered Expenses section for treatment of autism.
32. Vision Treatment, eye exercise, equipment or surgery to correct eyesight, such as laser treatment, refractive keratotomy (RK) and photorefractive Keratotomy (PRK). We will pay for eligible treatment or surgery of a detached retina, glaucoma, cataracts or keratoconus.
33. Vision Exams, Lenses and Hardware, including eyeglasses, contact lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye. This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
34. All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, Non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
35. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
36. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs or voluntary support groups.
37. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
38. Dental services or supplies except as specifically stated.
39. Orthodontia services, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces and retainers.
40. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
41. Blood administration for the purpose of general improvement in physical condition.
42. Cosmetics, dietary supplements and health and beauty aids.
43. Drugs, supplies, equipment or procedures to replace hair, slow hair loss or stimulate hair growth.

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44. All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
45. For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
46. Expenses incurred for treatment of sport-related accidental injury resulting from professional sports or participating in any practice or conditioning program for such sport, contest or completion.
47. Consultations provided using telephone, facsimile machine, or electronic mail.

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IMPORTANT CONTACT INFORMATION

Contact us ***anytime, anywhere!***

REACH US WORLDWIDE 24/7/365:

Toll-free within the U.S.
1-844-268-2686

Contact us through the **GeoBlue mobile app** or **Member Hub**

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