GeoBlue

Member Quick Guide

Your institution provides access to an international health plan from GeoBlue®. You can self-enroll online using a credit card. Visit the Resource Center on **www.geobluestudents.com** and enter your self-enrollment code listed below to review plan details and pricing.

Program Name: Western Michigan University
Policy Year: Aug. 28, 2024-Aug 27, 2025
Self-Enrollment Code: VLN-59113
Link: http://ogse.geobluestudents.com/?ac=VLN-59113

Accessing Care

What do I do in the event of a medical emergency?

If you have an emergency, dial 911 or go to the closest emergency room immediately. If you're not sure whether your situation is an emergency, dial 911 and let the call-taker determine if you need emergency help.

Need to speak to a doctor?

We've teamed up with Teladoc Health to bring you Global TeleMD™, a telemedicine smartphone app at no additional cost, that provides unlimited, 24/7/365 access to doctor consultations by telephone or video. Doctors are available worldwide. You can access Global TeleMD via the GeoBlue mobile app.

How can I find a provider if I do not want to use telemedicine?

Search for participating healthcare professionals or facilities via the provider directory on the Member Hub at **www.geobluestudents.com** or through the GeoBlue mobile app. You can view physician profiles to see if they are in the Blue Cross Blue Shield® network and contact them directly to schedule an appointment. At the time of service, you will need to show the provider your GeoBlue ID card to confirm you are covered by Blue Cross and Blue Shield. Depending on your coverage you may be responsible for a copayment, coinsurance, and/or deductible before a service is completed.

Want to speak to a counselor?

Try Global Wellness Assist. Global Wellness Assist is an assistance program for those traveling globally on behalf of a college or university, providing access to free, confidential assistance any time, any day. You can access Global Wellness Assist via the GeoBlue mobile app.

Using an out-of-network provider

This typically results in a higher coinsurance and may result in additional costs to you. If you receive care from an out-of-network provider, you may need to pay out-of-pocket and submit a claim for reimbursement.

Prescription Benefits

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

Using Your Plan

① Register for the GeoBlue Member Hub or mobile app

We encourage you to register for the Member Hub or mobile app for convenient access to a wide range of tools and services. Once you are enrolled with GeoBlue, you will receive a welcome email that contains all the information needed for your registration. The app is available from the Apple App Store or Google Play.

- Access your Certificate of Insurance for details on your benefits
- Access your GeoBlue ID card
- Print a verification of health insurance letter for your visa appointment
- Locate Blue Cross and Blue Shield providers and hospitals inside of the U.S.
- Access global health and safety tools including translations, medicine equivalents guide, news and safety information
- Submit and track claims

You can register online at **www.geobluestudents.com** or through the mobile app.

② Locate your digital ID card

It is important to have your GeoBlue ID card to access healthcare services; you will need to present your ID card whenever you receive medical care. This card can be accessed from multiple sources:

- Your ID card is available in the Member Hub on **www.geobluestudents.com** or on the mobile app
- You can display or email your ID card through the app

③ Submit claims

Submit claims electronically through the app or through the Member Hub on **www.geobluestudents.com**. If you prefer to submit a claim via postal mail, click "How to File Claims" in the Member Hub to download the appropriate claim form.

Questions? We're here for you 24/7/365 at **1-844-268-2686** (inside the U.S.) **+1-610-263-2847** (outside the U.S.)

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

Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health andthe performance the services by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member's health plan. This service is not intended to be used for emergency or urgent treatment medical questions.

Global Wellness Assist services are provided by WorkPlace Options, an independent company that is not affiliated with GeoBlue and does not provide Blue Cross or Blue Shield products or services. WorkPlace Options is solely responsible for referring participants for counseling, coaching and work-life services and health assessments by providers who are appropriately licensed by local authorities. The evaluation and efficacy of any service delivered by a provider lies solely with the employee, spouse, dependent or other authorized party who inquires on behalf of those or other participants. GeoBlue shall have no responsibility or liability whatsoever for any aspect of the provider counseling, coaching, work-life services and health assessments or other similar services, or the counselor/participant relationship.

GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued in the District of Columbia by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. This coverage is offered to the members of the Global Citizens Association, Washington, D.C.

GeoBlue

SCHL2309-MEM-3/22

Reviewing Plan Benefits

What is covered by your plan?

SCHEDULE OF BENEFITS
TABLE 1

	Limits Individual Insured	Limits Spouse	Limits Dependent Child(ren)
MEDICAL EXPENSES			
Coverage Year Limit	Unlimited	Unlimited	Unlimited
Coverage Year Deductible	$0 per Coverage Year	$0 per Coverage Year	$0 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 $6,500 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. Deductibles, Copayments, Prescription Drug Copayments and amounts above the maximums do not apply toward the Out-of-pocket Limit.	After the Covered Person reaches a $6,500 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. Deductibles, Copayments, Prescription Drug Copayments and amounts above the maximums do not apply toward the Out-of-pocket Limit.	After the Covered Person reaches a $6,500 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. Deductibles, Copayments, Prescription Drug Copayments and amounts above the maximums do not apply toward the Out-of-pocket Limit.
EMERGENCY TRANSPORTATION SERVICES			
Emergency Medical Evacuation	Maximum Benefit up to $250,000 per Coverage Year	Maximum Benefit up to $250,000 per Coverage Year	Maximum Benefit up to $250,000 per Coverage Year
Emergency Family Travel Arrangements	Maximum Benefit up to $1,500 per Coverage Year	Maximum Benefit up to $1,500 per Coverage Year	Maximum Benefit up to $1,500 per Coverage Year
Repatriation of Mortal Remains	Maximum Benefit up to $100,000 per Coverage Year	Maximum Benefit up to $100,000 per Coverage Year	Maximum Benefit up to $100,000 per Coverage Year
OTHER COVERAGES			
Accidental Death & Dismemberment	Maximum Benefit: Principal Sum up to $10,000	Maximum Benefit: Principal Sum up to $5,000	Maximum Benefit: Principal Sum up to $1,000

SCHEDULE OF BENEFITS
TABLE 2
MEDICAL EXPENSE BENEFITS

MEDICAL EXPENSES	Participating Provider+	Non-Participating Provider
Physician Office Visits*	100% of the Allowed Amount	70% of the Allowed Amount
Treatment at an Urgent Care Facility	100% of the Allowed Amount	70% of the Allowed Amount
Hospital and Physician Outpatient Services	100% of the Allowed Amount	70% of the Allowed Amount
Inpatient Hospital Services	100% of the Allowed Amount	70% of the Allowed Amount
Emergency Hospital Services	100% of the Allowed Amount	70% of the Allowed Amount

+Payment of Covered Medical Expenses for Participating Providers is based on the Allowed Amount. Participating Providers have agreed to accept the Allowed Amount as payment in full.

Reviewing Plan Benefits

What is covered by your plan?

*All Physician Visit Copayments and Deductibles for an Injury or Sickness are waived for treatment received at Recognized Student Health Center.

If a Covered Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

If a Covered Person incurs Covered Medical Expenses for services or supplies that are not of the type provided by any Preferred Provider, these Covered Medical Expenses will be treated as if they had been incurred at a Preferred Provider.

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
Maternity Care for a Covered Pregnancy	Allowed Amount
Complications of Pregnancy	Allowed Amount
Inpatient treatment of mental and nervous disorders including substance abuse	Reasonable Expenses up to $10,000 Maximum per Coverage Year for a maximum period of 30 days per Coverage Year.
Outpatient treatment of mental and nervous disorders including substance abuse	Reasonable Expenses up to $5,000 Maximum per Coverage Year for a maximum period of 30 visits per Coverage Year.
Treatment of specified therapies, including acupuncture and Physiotherapy	Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis.
Routine Preventive Care Services	Allowed Amount up to a Coverage Year Maximum of $1,000
Annual cervical cytology screening for women 18 and older	Allowed Amount
Low dose mammography screening, one baseline mammogram and one mammogram per year	Allowed Amount
Colorectal cancer screenings	Allowed Amount
Diabetic Supplies/Education	Allowed Amount
Prostate screening tests	Allowed Amount
Child Preventive and Primary Care Services	Allowed Amount
Breast Reconstruction due to Mastectomy	Allowed Amount
Repairs to sound, natural teeth required due to an Injury	Allowed Amount up to $500 per Coverage Year maximum
Outpatient prescription drugs including oral contraceptives and devices	100% of the Allowed Amount. Limited to a 31-day supply for initial fill or refill.

SECTION 7
PRE-EXISTING CONDITION LIMITATION

There is no limitation for Pre-Existing Conditions as defined under this Certificate.

Reviewing Plan Benefits

What is covered by your plan?

SECTION 8
GENERAL CERTIFICATE EXCLUSIONS

Unless specifically provided for elsewhere under the Certificate, the Certificate does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. Expenses incurred in excess of Reasonable Expenses.
2. Services or supplies that the Insurer considers to be Experimental or Investigative.
3. Expenses incurred prior to the beginning of the current Period of Coverage or after the end of the current Period of Coverage except as described in Covered General Medical Expenses and Limitations and Extension of Benefits.
4. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health, unless otherwise noted.
5. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury, unless otherwise noted.
6. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eyeglasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
7. 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.
8. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided for in the Certificate.
9. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Certificate and performed while the Certificate is in effect.
10. For diagnostic investigation or medical treatment for reproductive services, infertility, fertility, or for male or female voluntary sterilization procedures, or the reversal male or female voluntary sterilization procedures.
11. Expenses incurred for, or related to, sex change surgery.
12. Organ or tissue transplant.
13. Participating in an illegal occupation or committing or attempting to commit a felony.
14. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
15. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Certificate.
16. Expenses incurred within the Covered Person's Home Country.
17. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, unless otherwise noted.
18. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
19. Diagnosis and treatment of acne.
20. Diagnosis and treatment of sleep disorders.
21. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.
22. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
23. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
24. Expenses incurred for any services rendered by a family member or a Covered Person's immediate family or a person who lives in the Covered Person's home.
25. Unless specifically provided for elsewhere under the Certificate, the cost of treatment or services that are provided normally without charge by the Member's Student Health Center, covered or provided by the student health fee, rendered by a person employed by the Member, including team Doctor and trainers or any other service performed at no cost.
26. Loss due to an act of war; service in the armed forces of any country or international authority and Participation in a Riot or Civil Commotion.
27. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.

Reviewing Plan Benefits

What is covered by your plan?

28. Loss arising from:
    a. participating in any intercollegiate/interscholastic or professional sports, contest or competition;
    b. participating in any club sport competition, contest or competition;
    c. Racing or speed contests;
    d. SCUBA diving, sky diving, mountaineering (where ropes or other climbing gear is customarily used), ultra-light aircraft, parasailing, sailplaning/gliders, hang gliding, parachuting, or bungee jumping.
29. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
30. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
31. Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
32. Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
33. Routine hearing tests except as provided under Preventive and Primary Care.
34. Expense covered under any Other Plan.
35. To the extent that such payments would be prohibited by law.

MONTHLY	GROUP RATE
PARTICIPANT	$159.05
SPOUSE	$477.05
CHILD	$477.05
CHILDREN	$954.10

Annual 8/28/24 -8/27/25	GROUP RATE
PARTICIPANT	$1,908.60
SPOUSE	$5,724.60
CHILD	$5,724.60
CHILDREN	$11,449.20

FALL 8/28/24 -12/31/24	GROUP RATE
PARTICIPANT	$636.20
SPOUSE	$1,908.20
CHILD	$1,908.20
CHILDREN	$3,816.40

Reviewing Plan Benefits

What is covered by your plan?

SPRING 1/1/24 -4/30/24	GROUP RATE
PARTICIPANT	$636.20
SPOUSE	$1,908.20
CHILD	$1,908.20
CHILDREN	$3,816.40

EARLY SPRING 12/1/24 -4/30/24	GROUP RATE
PARTICIPANT	$795.25
SPOUSE	$2,385.25
CHILD	$2,385.25
CHILDREN	$4,770.50

SUMMER 5/1/25 -8/27/25	GROUP RATE
PARTICIPANT	$636.20
SPOUSE	$1,908.20
CHILD	$1,908.20
CHILDREN	$3,816.40

EARLY SUMMER 4/1/25 -8/27/25	GROUP RATE
PARTICIPANT	$795.25
SPOUSE	$2,385.25
CHILD	$2,385.25
CHILDREN	$4,770.50