UnitedHealthcare® Global

YOUR BENEFITS

Benefit Summary

Texas - Insurance Choice Plus
Expatriate Insurance - 15/1000/100% Plan 1012A

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **International Service Center Customer Care telephone support** – Need more help? Call our international customer service center 24 hours a day, 7 days a week, using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

PLAN HIGHLIGHTS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	International: No Annual Deductible U.S. Network: $1,000 per year	$2,000 per year
Family Deductible	International: No Annual Deductible U.S. Network: $3,000 per year	$6,000 per year

> Copayments do not accumulate towards the Deductible unless otherwise notated within the specific Benefit category below.

> All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

Out-of-Pocket Maximum (Combined International and U.S. Network)		
Individual Out-of-Pocket Maximum	International: No Out-of-Pocket Maximum U.S. Network: $2,000 per year	$4,000 per year
Family Out-of-Pocket Maximum	International: No Out-of-Pocket Maximum U.S. Network: $6,000 per year	$12,000 per year

> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

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Prescription Drug Benefits

U.S. Prescription drug benefits are shown under separate cover.

Benefit Plan Coinsurance - The Amount We Pay

	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid.

> When Benefit limits apply, the limit refers to any combination of International, U.S. Network and Non-Network Benefits unless specifically stated in the Benefit category.

MOST COMMONLY USED BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit No deductible is applicable to necessary diagnostic follow-up care relating to the screening test for hearing loss of newborn Dependents, from birth through 24 months.	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $15 Copayment per visit.	80% after Deductible has been met.
Specialist Physician Office Visit No deductible is applicable to necessary diagnostic follow-up care relating to the screening test for hearing loss of newborn Dependents, from birth through 24 months.	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $30 Copayment per visit.	80% after Deductible has been met. *Prior Authorization is required for Genetic Testing - BRCA.*

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	International: 100%, Copayments and Deductibles do not apply. U.S. Network: 100%, Copayments and Deductibles do not apply.	80% after Deductible has been met.
Specialist Physician Office Visit	International: 100%, Copayments and Deductibles do not apply. U.S. Network: 100%, Copayments and Deductibles do not apply.	
Lab, X-Ray or other preventive tests	International: 100%, Copayments and Deductibles do not apply. U.S. Network: 100%, Copayments and Deductibles do not apply.	
The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.		
Urgent Care Center Services		
	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $50 Copayment per visit.	80% after Deductible has been met.
> In addition to the Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
Emergency Health Services - Outpatient		
	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $200 Copayment per visit.	100% after you pay a $200 Copayment per visit. *Notification is required if confined in a non-Network Hospital.*
Hospital - Inpatient Stay		
	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required.*

ADDITIONAL CORE BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Acupuncture		
Benefits are limited as follows: $2,500 in Eligible Expenses per year	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $15 Copayment per visit.	80% after Deductible has been met.
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	100% after U.S. Network Deductible has been met.
Air Ambulance	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met. *For U.S. Network Benefits, Prior Authorization is required for non-Emergency Ambulance.*	100% after U.S. Network Deductible has been met. *Prior Authorization is required for non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required.*
Dental Services - Accident Only		
	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met. *For U.S. Network Benefits, Prior Authorization is required.*	100% after U.S. Network Deductible has been met. *Prior Authorization is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.	International: For diabetes equipment, Benefits will be the same as those stated under Durable Medical Equipment. For diabetes supplies the Benefit is 100% of Eligible Expenses and Benefits are not subject to payment of the Annual Deductible. Coinsurance applies to the Out-of-Pocket Maximum. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.	*Prior Authorization is required for diabetes equipment in excess of $1,000.*

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Durable Medical Equipment		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required for Durable Medical Equipment in excess of $1,000.*
Habilitative Services		
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.	
Hearing Aids		
Benefits are limited as follows: A single purchase (including repair/ replacement) per hearing impaired ear every three years.	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 120 visits per year This visit limit does not include any service which is billed only for the administration of intravenous infusion.	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required.*
Hospice Care		
	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required for Inpatient Stay.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	International: 100% Deductible does not apply. U.S. Network: 100% Deductible does not apply.	80% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	International: 100% Deductible does not apply. U.S. Network: 100% Deductible does not apply.	80% after Deductible has been met. *Prior Authorization is required for sleep studies.*

ADDITIONAL CORE BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required.*
Ostomy Supplies		
Benefits are limited as follows: $2,500 per year	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met.
Pregnancy - Maternity Services and Complications of Pregnancy		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Prior Authorization is required if Inpatient Stay exceeds 48 hours following an uncomplicated normal vaginal delivery or 96 hours following an uncomplicated cesarean section delivery.*
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years. Note: Benefits for Prosthetic Devices for Artificial Arms and Legs can be found under Orthotic Devices and Prosthetic Devices - Artificial Arms and Legs in the Additional Benefits Required by State Law section in this Benefit Summary.	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required for Prosthetic Devices in excess of $1,000.*
Reconstructive Procedures		
For U.S. Network and Non-Network Benefits, for Covered Persons under the age of 18, Benefits are provided for the reconstructive procedures for craniofacial abnormalities.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Prior Authorization is required.*

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of Manipulative Treatments 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $15 Copayment per visit.	80% after Deductible has been met. *Prior Authorization is required for certain services.*
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 120 days per year	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required.*
Surgery - Outpatient		
	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required for certain services.*
Temporomandibular Joint Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Benefit Summary.	*Prior Authorization is required for Inpatient Stay.*

ADDITIONAL CORE BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met. *Prior Authorization is required for certain services.*
Transplantation Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For U.S. Network Benefits, services must be received at a Designated Facility. We will refer you to the Designated Facility most suitable, in our opinion, to treat your condition. In the event that the selected Designated Facility is located outside of Texas and you do not wish to travel outside the state, we shall refer you to an alternate Designated Facility within the State of Texas. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. *For International and U.S. Network Benefits, Prior Authorization is required.*	*Prior Authorization is required.*
Vision Examinations		
Benefits are limited as follows: 1 exam every 2 years	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $15 Copayment per visit.	80% after Deductible has been met.
Wigs		
Benefits are limited as follows: $5,000 every 24 months	International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	80% after Deductible has been met.

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Acquired Brain Injury		
Outpatient Post- Acute Transition Services and Post-acute Care Treatment Services	International: 100% Deductible does not apply. U.S. Network 100% after you pay a $15 Copayment per visit.	80% after Deductible has been met.
Inpatient Post-acute Transition Services and Post-acute Care Treatment Services	International: 100% Deductible does not apply. U.S. Network 100% after you pay a $15 Copayment per visit.	80% after Deductible has been met.
All other Covered Services	International: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For U.S. Network Benefits, Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Amino Acid-Based Elemental Formulas		
	International: If an Outpatient Prescription Drug Rider is included under this Policy, Benefits for the amino acid-based elemental formulas will be provided as described under the Outpatient Prescription Drug Rider. Otherwise, Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. U.S. Network and Non-Network: If an Outpatient Prescription Drug Rider is included under this Policy, Benefits for the amino acid-based elemental formulas will be provided as described under the Outpatient Prescription Drug Rider. Otherwise, Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Autism Spectrum Disorder Services		
	International: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For U.S. Network Benefits, Prior Authorization is required for certain services.	*Prior Authorization is required for certain services.*

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. International: To be a qualifying clinical trial for services outside the United States, a clinical trial must meet all of the criteria as described under Clinical Trials in the Expatriate Insurance Rider. *For U.S. Network Benefits, Prior Authorization is required.*	*Prior Authorization is required.*
Developmental Delay Services		
Benefits are paid at the same level as Benefits for any other Covered Health Service, except that the Benefit limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to services for developmental delays.	International: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Mental Health Services and Serious Mental Health Services		
	Inpatient: International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met. Outpatient: International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $15 Copayment per visit.	Inpatient: 80% after Deductible has been met. Outpatient: 80% after Deductible has been met. *Prior Authorization is required for certain services.*
Neurobiological Disorders – Autism Spectrum Disorder Services		
	Inpatient: International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met. Outpatient: International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $15 Copayment per visit.	Inpatient: 80% after Deductible has been met. Outpatient: 80% after Deductible has been met. *Prior Authorization is required for certain services.*

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs		
	International: 100% Deductible does not apply. U.S. Network 100% after Deductible has been met.	80% after Deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required for Prosthetic Devices in excess of $1,000.	*Prior Authorization is required for Prosthetic Devices in excess of $1,000.*
Osteoporosis Detection and Prevention		
	International: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Substance Use Disorder Services and Chemical Dependency Services		
	Inpatient: International: 100% Deductible does not apply. U.S. Network: 100% after Deductible has been met.	Inpatient: 80% after Deductible has been met.
	Outpatient: International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $15 Copayment per visit.	Outpatient: 80% after Deductible has been met. *Prior Authorization is required for certain services.*

ADDITIONAL INTERNATIONAL BENEFITS

Types of Coverage	International Benefits
Culturally-Based Services	
Services provided outside the United States that reflect the medical standards of the country in which the service is provided, but which may otherwise be considered alternative treatments when provided within the United States as described under Culturally-Based Services in the Expatriate Insurance Rider.	100% Deductible does not apply.
Emergency Evacuation	
A per-diem of $300 for up to 30 days to cover living expenses for the person(s) accompanying the Covered Person at the evacuation destination.	100% Deductible does not apply. If you suffer a Sickness or Injury and adequate medical facilities are not available locally in the opinion of the attending Physician or our Medical Director or the Medical Director of our affiliate or authorized vendor under our discretion, we will provide emergency evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. Benefits include arranging and providing for transportation and related medical services (including cost of medical escort) and medical supplies incurred in connection with the emergency evacuation. Transportation of your children (under the age of 18) either to the same location as the Covered Person or to a location where the children can be placed under the care of another guardian or relative. *You must notify us as soon as the possibility of Emergency Evacuation arises. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.*
Emergency Family Reunion	
A per diem for living expenses for immediate family members of $300 while the Covered Person is hospitalized up to 30 days.	100% Deductible does not apply. In the event that you are hospitalized for more than 7 days or in the event of your death, Benefits are available to transport your immediate family members to join you. *You must notify us as soon as the possibility of Emergency Family Reunion Benefits arises. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.*
Medical Repatriation	
Benefits include Repatriation of Children (under age 18).	100% Deductible does not apply. After you receive initial treatment and stabilization for a Sickness or Injury, if the attending Physician and our Medical Director or the Medical Director of our affiliate or authorized vendor under our direction determine that it is appropriate to facilitate your recovery, we will transport you back to your permanent place of residence for further medical treatment or to recover. The timing and method of transportation will be determined solely by us and will be suitable to accommodate your medical needs. Covered Services include arranging and providing for transportation and related medical services (including medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation. *You must notify us to obtain Benefits for Medical Repatriation. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.*
Outpatient Prescription Drugs	
	100% Deductible does not apply.

Types of Coverage	International Benefits
Repatriation of Remains	
Benefits include Return of Children (under age 18).	100% Deductible does not apply. In the event of your death, we or our affiliate or authorized vendor will render assistance and provide for the return of your mortal remains to your permanent place of residence. *You must notify us to obtain Benefits for Repatriation of Remains. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.*

EXCLUSIONS

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage. These exclusions apply to the International, U.S. Network and Non-Network Benefit unless otherwise indicated below.

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC. Please note that the exclusions for Alternative Treatments in the Certificate do not apply to any service, therapy or treatment provided outside the United States that is determined to be a Covered Health Services as described under Culturally-Based Services in this Benefit Summary.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Services required by a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia because of a documented physical, mental or medical reason. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to orthotic devices as described under Orthotic Devices and Prosthetic Devices -for Artificial Arms and Legs in Section 1 of the COC. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic or orthotic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic or orthotic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. (This exclusion does not apply to International Benefits).This exclusion does not apply to prescription and non-prescription oral agents for controlling blood sugar levels. Note: If an Outpatient Prescription Drug Rider is included under the Policy, Benefits for the prescription and non-prescription oral agents will be provided under the Outpatient Prescription Drug Rider. Otherwise, the Benefits will be provided under the Certificate. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes. Shoe orthotics. This exclusion does not apply to podiatric appliances or therapeutic footwear as described under Diabetes Services or Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs in Section 1 of the COC. Shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities and Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Please Note: The Mental Health exclusion section excludes Autism Spectrum Disorders because treatment for Autism Spectrum Disorders are not covered/provided under the Mental Health Services in section 1 of the COC. Instead, Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Neurobiological Disorders – Autism Spectrum Disorder

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Services as treatment of learning, motor disorders and communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC. Infant formula and donor breast milk. This exclusion does not apply to amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to:

- Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in Section 1 of the COC, which meet the definition of a Covered Health Service.
- Amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC.
- Formulas for phenylketonuria (PKU) or other heritable diseases.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to Benefits described under Temporomandibular Joint Syndrome in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. This exclusion does not apply to dentists. Services performed by a provider with your same legal residence. This exclusion does not apply to dentists. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, Defense Base Act (DBA) coverage (for International Benefits), no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services provided while you are covered under a separate policy issued through your Enrolling Groups as stipulated by a foreign governmental requirement (for International Benefits only). For U.S. Benefits: Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

For U.S. Benefits: Health services provided in a foreign country, unless required as Emergency Health Services. Health services provided in a foreign country, except for those services specifically described as Covered Health Services in this Benefit summary (for International Benefits). Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to Emergency Evacuation, Medical Repatriation, Repatriation of Remains and Emergency Family Reunion for which Benefits are described in this Benefit Summary.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when claims payment and/or coverage is prohibited by applicable law.