

SERFF Tracking Number: INCS-127844361 State: Arkansas  
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 50329  
Company Tracking Number: GLBSOL.09R2.AR  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002C Large Group Only - Other  
Product Name: UHC Global Solutions Rider  
Project Name/Number: UHC Global Solutions Rider/UHC GLBSOL.09R2

## Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: UHC Global Solutions Rider SERFF Tr Num: INCS-127844361 State: Arkansas  
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 50329  
Closed

Sub-TOI: H16G.002C Large Group Only - OtherCo Tr Num: GLBSOL.09R2.AR State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Author: Renee Weaver Disposition Date: 11/30/2011  
Date Submitted: 11/23/2011 Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date: 11/30/2011

State Filing Description:

## General Information

Project Name: UHC Global Solutions Rider  
Project Number: UHC GLBSOL.09R2  
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: does not require  
prior approval

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 11/30/2011

State Status Changed: 11/30/2011

Deemer Date:

Created By: Renee Weaver

Submitted By: Renee Weaver

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Re: UnitedHealthcare Insurance Company

NAIC No. 79413

Group Health Form: GLBSOL.09R2.AR (Global Solutions Rider) Flesch Score: 48.6

This filing is being made by Innovative Compliance Solutions, LLC on behalf of UnitedHealthcare Insurance Company.

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The enclosed group health form is being submitted to your Department for review and approval. This is a new Rider and will not replace any form previously filed with the Department.

This Rider is identical to the Rider that was approved by the Department on 1/18/11 under SERFF tracking number: INCS-126985070 except for the following change: We add reference to "Key Local Nationals" (KLN) as an eligible subscriber under the Global Solutions Rider. Essentially a KLN is a person that the company feels is key to the operation of the company and is employed and resides in their home country. When the KLN leaves their home country for any amount of time, they would then be considered an Expatriate under the Rider. No other changes have been made to the Rider.

This Rider will be used in the same way the previous Rider was approved. It will be used with our current 2009 Group Policy (form POL.1.09.AR) and Certificate of Coverage series of forms (including all other approved riders and amendments for that series) which was approved by your department. The Global Solutions Rider has been designed to allow employer groups to elect to provide benefits for expatriate employees who are on assignment in any country outside the United States. When these employees are within the United States, they will have coverage under one of our standard products (Choice Plus, Options PPO or Non-Differential PPO). However, because these standard products exclude coverage for services outside the United States (except in the case of an Emergency) we've developed this Rider to add on a basic set of covered services available only when the insured resides outside the United States.

This Rider will be used to support the issuance of our portfolio of group health products for Global Solutions. This Rider represents final printed format (with the exception of variable text and corresponding instructions—please see the following paragraphs for explanation).

#### Explanation of Variable Text

The form is made up of:

1. Nonvariable Text that always appears in an issued document.
2. Variable Text that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets]. Whenever text is bracketed, we have included text that explains the logic of the variable; brackets do not appear in the document issued to a member. Variable text will appear unbracketed in the final documents issued to the employer and/or member.
3. The instruction text in the gray boxes provides the logic for when text is included or removed. Please note that instruction text appears only in the filing copy and will not appear in the document issued to a member.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

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If you have any questions or concerns regarding this submission, please feel free to contact me.

Sincerely,

Renee Weaver  
 Innovative Compliance Solutions  
 Compliance Consultant

Ph: 763-323-8643  
 Email: rweaver@innovative-compliance.com

## Company and Contact

### Filing Contact Information

Renee Weaver, Consultant rweaver@innovative-compliance.com  
 PO Box 773 763-323-8643 [Phone]  
 Anoka, MN 55303 763-712-8001 [FAX]

### Filing Company Information

(This filing was made by a third party - innovativecompliancesolutions)

UnitedHealthcare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
185 Asylum Street	Group Code:	Company Type:
Hartford, CT 06103	Group Name:	State ID Number:
(800) 357-1371 ext. [Phone]	FEIN Number: 36-2739571	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50 PER RIDER
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$50.00	11/23/2011	54026482

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/30/2011	11/30/2011

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## Disposition

Disposition Date: 11/30/2011  
 Implementation Date: 11/30/2011  
 Status: Approved-Closed  
 HHS Status: HHS Approved  
 State Review: Reviewed-No Actuary  
 Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
UnitedHealthcare Insurance Company	%	%	\$		\$	%	%
	<b>Percent Change Approved:</b>						
	<b>Minimum:</b>	%	<b>Maximum:</b>	%	<b>Weighted Average:</b>		%

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	Yes
<b>Supporting Document</b>	AUTHORIZATION LETTER	Approved-Closed	Yes
<b>Form</b>	GLOBAL SOLUTIONS RIDER	Approved-Closed	Yes

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## Form Schedule

Lead Form Number: GLBSOL.09R2.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 11/30/2011	GLBSOL.09R2.AR	Policy/Contract/ Certificate: Amendment, Insert Page, Endorsement or Rider	GLOBAL SOLUTIONS RIDER	Initial		48.600	X09I_RDR_G S_REV 3 8- 11 GLBSOL.09. R2 AR.pdf

# [UnitedHealthcare Insurance Company [of \_\_\_\_\_]]

NOTE: Product name of "Global Solutions" filed as variable to allow name change in future.

## [Global Solutions] Rider

<sup>1</sup>Include when International Benefits are available to Key Local Nationals.

<sup>2</sup>Include when International Benefits are available to Enrolled Dependents.

This Rider to the Policy provides Benefits for Covered Health Services that are provided outside the United States to Subscribers who are Expatriates [<sup>1</sup>or Key Local Nationals] [<sup>2</sup>and to their Enrolled Dependents].

### International Benefits

<sup>1</sup>Include when International Benefits are available to Key Local Nationals.

<sup>2</sup>Include when International Benefits are available to Enrolled Dependents.

We will pay Benefits for Covered Health Services provided by or under the direction of a Physician to Subscribers who are Expatriates [<sup>1</sup>or Key Local Nationals] [<sup>2</sup>and to their Enrolled Dependents]. An Expatriate is an Eligible Person who is sent on assignment outside his or her own country, as agreed upon between the Enrolling Group and us. [<sup>1</sup>A Key Local National is an Eligible Person that works and resides within their country of citizenship and who the Enrolling Group has determined is eligible under the Policy as a condition of their employment and/or because they are essential to the management of their work country's operation.]

*Include when International Benefits are available only within the country or geographic region to which the Expatriate has been sent on assignment. <sup>1</sup>Include when International Benefits are also available to Key Local Nationals. <sup>2</sup>Include when this limit applies also to Enrolled Dependents. <sup>3</sup>Include only when the Expatriate's home country is not the United States. <sup>4</sup>Select either country or geographic region.*

[International Benefits are available only for Covered Health Services provided to the [<sup>1</sup>Expatriate] Subscriber [<sup>2</sup>and to their Enrolled Dependents] [<sup>3</sup>within the Expatriate's home country or] within the [<sup>4</sup>country] [<sup>4</sup>geographic region] to which the Expatriate has been sent on assignment.]

*Include when International Benefits are available for Enrolled Dependents only when they reside with the Expatriate in the country to which the Expatriate has been sent on assignment. <sup>1</sup>Include when International Benefits are also available to Key Local Nationals.*

[International Benefits are available for Enrolled Dependents [<sup>1</sup>of Expatriate Subscribers] only when the Enrolled Dependent resides with the Expatriate in the country to which the Expatriate has been sent on assignment.]

*Include when International Benefits are available to Key Local Nationals.*

<sup>1</sup>Include when International Benefits are available for Enrolled Dependents.

[International Benefits are only available for Covered Health Services provided to the Key Local National Subscriber [<sup>1</sup>and to their Enrolled Dependents] within the Key Local National's home country.]

### Benefits

International Benefits are provided under this Rider for the Covered Health Services identified below in the *Schedule* and as described in more detail in the *Certificate* under *Section 1: Covered Health Services*. International Benefits are subject to all other terms, conditions, exclusions and limitations of the Policy, *Certificate* and *Schedule of Benefits* unless otherwise modified by this Rider.

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
<p><b>Annual Deductible</b></p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p><i>Include when day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</i></p> <p>[Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]</p> <p><i>Include when dollar limits are reduced by the amount used toward meeting the deductible.</i></p> <p>[Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a dollar limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the amount used toward meeting the Annual Deductible.]</p> <p><i>Include when the carry-over provision applies.</i></p> <p>[Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p><i>Include paragraph if the roll-over provision applies to a group in any circumstance.</i></p> <p>[When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p><i>Include paragraph if the roll-over provision applies to a group changing from a calendar year to Policy year plan. <sup>1</sup>Include when this applies only to the individual deductible.</i></p> <p>[When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [<sup>1</sup>This roll-over feature applies only to the individual Annual Deductible.]]</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i></p>	<p><sup>1</sup><i>Include when plan design includes a combined Network/International deductible.</i></p> <p><i>Note: If a combined deductible applies, the \$ amounts listed below must be the same as the \$ amounts reflected for Network deductible in the Schedule of Benefits.</i></p> <p><b>[<sup>1</sup> Network and] International Benefits</b></p> <p><i>Include when separate individual and family deductibles apply (non-embedded).</i></p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p><i>Include when individual deductible applies (embedded).</i></p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p><i>Include when individual (with family maximum) deductible applies (embedded).</i></p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p><i>Include when there is no annual deductible for International benefits.</i></p> <p>[No Annual Deductible.]</p> <p>[<sup>1</sup>The Annual Deductible listed above includes any combination of amounts paid toward the Annual Deductible for Covered Health Services provided by or under the direction of a Physician outside the <i>United States</i> as described in this Rider and amounts paid toward the Network Annual Deductible described in the Schedule of Benefits.]</p>

table.	
<p><i>Include only when a per occurrence deductible applies.</i></p> <p><b>[Per Occurrence Deductible]</b></p>	
<p>[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Per Occurrence Deductible.</li> <li>• The Eligible Expense.]</li> </ul>	<p><b>[International Benefits]</b></p> <p><i>Include when a per occurrence deductible applies to CHD surgery benefits.</i></p> <p>[CHD surgery - Inpatient Stay: [\$100 - 1,000] per day.]</p> <p>[CHD surgery - Inpatient Stay: [\$100 - 2,000] per Inpatient Stay.]</p> <p><i>Include when a per occurrence deductible applies to inpatient hospital benefits.</i></p> <p>[Hospital - Inpatient Stay: [\$100 - 1,000] per day.]</p> <p>[Hospital - Inpatient Stay: [\$100 - 2,000] per Inpatient Stay.]</p> <p><i>Include when a per occurrence deductible applies to outpatient surgery benefits.</i></p> <p>[Surgery - Outpatient: [\$10 - 1,000] per date of service.]</p> <p><i>Include when a per occurrence deductible applies to inpatient transplant benefits.</i></p> <p>[Transplant - Inpatient Stay: [\$100 - 1,000] per day.]</p> <p>[Transplant - Inpatient Stay: [\$100 - 2,000] per Inpatient Stay.]</p>
<p><b>Out-of-Pocket Maximum</b></p>	
<p><sup>1</sup><i>Include when OOPM includes the Annual Deductible.</i></p> <p><sup>2</sup><i>Include when OOPM includes Copayments.</i></p> <p>The maximum you pay per year for [<sup>1</sup>the Annual Deductible,] [<sup>2</sup>Copayments] [<sup>1-2</sup>or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year.</p> <p><sup>3</sup><i>Include only when the plan design does not apply all Copayments/Coinsurance to the OOPM.</i></p> <p>[<sup>3</sup>Copayments and Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of</p>	<p><sup>1</sup><i>Include when plan design includes a combined Network/International Out-of-Pocket Maximum.</i></p> <p><i>Note: If a combined OOPM applies, the \$ amounts listed below must be the same as the \$ amounts reflected for Network OOPM in the Schedule of Benefits.</i></p> <p><b>[<sup>1</sup> Network and] International Benefits</b></p> <p><i>Include when separate individual and family maximums apply (non-embedded).</i></p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered</p>

<p>the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> <li>Any charges for non-Covered Health Services.</li> </ul> <p><i>Include bullet if notification requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.</i></p> <ul style="list-style-type: none"> <li>[The amount Benefits are reduced if you do not notify us as required.]</li> <li>Charges that exceed Eligible Expenses.</li> <li>Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum.</li> </ul>	<p>Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p><i>Include when individual OOPM applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p><i>Include when individual (with family maximum) applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p><i>Include when the OOPM includes the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p><i>Include when the OOPM does not include the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p><i>Include when there is no OOPM.</i></p> <p>[No Out-of-Pocket Maximum.]</p> <p>[<sup>1</sup>The Out-of-Pocket Maximum listed above includes any combination of amounts paid toward the Out-of-Pocket Maximum for Covered Health Services provided by or under the direction of a Physician outside the <i>United States</i> as described in this Rider and amounts paid toward the Network Out-of-Pocket Maximum described in the Schedule of Benefits.]</p>
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**Copayment**

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

**Coinsurance**

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

*Include when benefit limits are combined.*

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>Include for groups that purchase benefits for acupuncture services.</i>			
<b>1. [Acupuncture Services]</b>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to [10 - 100] visits per year.]</p> <p>[Limited to [10 - 100] visits per year, not to exceed \$[100 - 5,000] in Eligible Expenses per year.]</p> <p>[Limited to \$[100 - \$5,000] in Eligible Expenses per year.]</p>	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<b>[2.] Ambulance Services</b>			
<p><b>Pre-service Notification Requirement</b></p> <p><sup>1</sup><i>Include when failure to notify results in no Benefits.</i></p> <p><sup>2</sup><i>Include when Benefits for Emergency Evacuation are sold.</i></p> <p>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify us as soon as possible prior to transport. [<sup>1</sup>If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.]</p> <p>[<sup>2</sup>Please note that Benefits under this section do not include emergency evacuation. See <i>Emergency Evacuation</i> described below.]</p>			
<b>Emergency Ambulance</b>	<p><b>International Benefits</b></p> <p><i>Ground Ambulance:</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 300] per transport]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><b>Non-Emergency Ambulance</b> Ground or air ambulance, as we determine appropriate.</p>	<p>[100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p> <p><i>Air Ambulance:</i> [[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 - 2,500] per transport]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p> <p><b>International Benefits</b></p> <p><i>Ground Ambulance:</i> [[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 - 300] per transport]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
	<p><i>Air Ambulance:</i> [[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

***[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]***

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

<b>Covered Health Service</b>	<b>Benefit (The Amount We Pay, based on Eligible Expenses)</b>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
	2,500] per transport] [100% after you pay a Copayment of \$[2,500 - 10,000] per day] [100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]		
<i>Include for groups that purchase benefits for clinical trials.</i> <b>[3.] [Clinical Trials]</b>			
<i>Include when pre-service notification is required.</i> <sup>1</sup> <i>Include when failure to notify results in no Benefits.</i>			
<p align="center"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us as soon as the possibility of participation in a clinical trial arises. [<sup>1</sup>If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]]</p>			
<i>Always include criteria below when Clinical Trial benefits are sold.</i>			
<p>[To be a qualifying clinical trial for services outside the <i>United States</i>, a clinical trial must meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>• The clinical trial must be situated in the country in which you physically reside.</li> <li>• The clinical trial must be sponsored by an entity or government agency that has been designated by the government of the country of assignment, or otherwise authorized by applicable law to sponsor or conduct clinical trials.</li> <li>• The clinical trial must satisfy all legal and/or regulatory requirements of the country of assignment necessary to conduct a clinical trial in the country of assignment.</li> <li>• The clinical trial must be conducted pursuant to the oversight of an independent ethical committee (<i>IEC</i>), defined as a review panel that is responsible for ensuring the protection of the rights, safety, and well-being of human subjects involved in a clinical investigation and is adequately constituted to provide assurance of that protection.</li> <li>• The clinical trial must be conducted in compliance with the <i>United States Food and Drug Administration's (FDA) Good Clinical Practice (GCP)</i> regulations.</li> <li>• The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.]</li> </ul>			

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .]	<p><b>[International Benefits]</b></p> <p>[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 <i>Schedule of Benefits</i>.]</p>		
<p><i>Include for groups that purchase benefits for congenital heart disease services.</i></p> <p><b>[4.] [Congenital Heart Disease Surgeries]</b></p>			
<p><i>Include if pre-service notification is required.</i></p>			
<p align="center"><b>[Pre-service Notification Requirement]</b></p>			
<p><sup>1</sup>Include when penalty for non-notification applies.</p>			
<p><sup>2</sup>Include applicable reduction in Benefits.</p>			
<p>[You must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. [<sup>1</sup>If you don't notify us, Benefits will be reduced to [<sup>2</sup>50 - 95] % of Eligible Expenses].]</p>			
<p><i>Include when CHD benefits are sold.</i></p> <p>[Benefits under this section include only the Congenital Heart Disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>	<p><b>[International Benefits]</b></p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><i>Include for groups that purchase benefits for accident-related dental services.</i></p> <p><b>[5.] [Dental Services - Accident]</b></p>			

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

Please refer to **Section 1: Covered Health Services** of the **Certificate** for coverage details that apply to each of the Benefit categories listed below.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Only]			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>2</sup><i>Include applicable reduction in Benefits or no Benefits.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.) [<sup>1</sup>If you fail to notify us as required, [<sup>2</sup>Benefits will be reduced to [50 - 95]% of Eligible Expenses] [<sup>2</sup>you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]</p>	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<b>[6.] Diabetes Services</b>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when the durable medical equipment benefit is sold.</i></p> <p><sup>2</sup><i>Include when the durable medical equipment benefit is not sold.</i></p> <p><sup>3</sup><i>Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.</i></p> <p><sup>4</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>5</sup><i>Select either the applicable reduction in Benefits or no Benefits.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us before obtaining any [<sup>1</sup>Durable Medical Equipment] [<sup>2</sup>diabetes equipment] for the management and treatment of diabetes [<sup>3</sup>that exceeds \$[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. [<sup>4</sup>If you fail to notify us as required, [<sup>5</sup>Benefits will be reduced to [50 - 95]% of Eligible Expenses] [<sup>5</sup>you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p><b>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</b></p>	<p><b>International Benefits</b></p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of</i></p>		

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><b>Diabetes Self-Management Items</b></p> <p>Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i>.</p> <p><i>Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.</i></p> <p>[Benefits for insulin pumps are limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]</p>	<p><i>Benefits.</i></p> <p><b>International Benefits</b></p> <p><i>Include when benefits for durable medical equipment are sold.</i></p> <p><sup>1</sup><i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p><sup>2</sup><i>Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</i></p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [<sup>1</sup>and Benefits [are] [are not] subject to payment of the Annual Deductible]. [<sup>2</sup>Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>Include when benefits for durable medical equipment are not sold.</i></p> <p><sup>1</sup><i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p><sup>2</sup><i>Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [<sup>1</sup>and Benefits [are] [are not] subject to payment of the Annual Deductible]. [<sup>2</sup>Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
<p><i>Include for groups that purchase benefits for DME.</i></p> <p><b>[7.] [Durable Medical Equipment]</b></p>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.</i></p> <p><sup>2</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>3</sup><i>Include applicable reduction in Benefits or no Benefits.</i></p> <p><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us before obtaining any Durable Medical Equipment [<sup>1</sup>that exceeds \$[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. [<sup>2</sup>If you fail to notify us as required, [<sup>3</sup>Benefits will be reduced to [50 - 95]% of Eligible Expenses] [<sup>3</sup>you will be responsible for paying all</p>			

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**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
charges and no Benefits will be paid].]			
<p><i>Include the limit selected by the group.</i></p> <p><i><sup>1</sup>Include either option as standard plan design.</i></p> <p>[<sup>1</sup>Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p>[<sup>1</sup>Limited per year as follows:</p> <ul style="list-style-type: none"> <li>• [[\$500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.]</li> <li>• [[\$10,001 - 25,000] in Eligible Expenses for Tier 2.]</li> <li>• [[\$25,001 - 100,000] in Eligible Expenses for Tier 3.]</li> </ul> <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p><i><sup>1</sup>Include when Benefits are provided for speech aid and tracheo-esophageal voice devices.</i></p> <p><i><sup>2</sup>Include when devices are not included in the annual DME limit.</i></p> <p>[<sup>1</sup>Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [<sup>2</sup>not] included in the</p>	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
annual limits stated above.]			
<b>[8.] Emergency Health Services - Outpatient</b>			
	<p><b>International Benefits</b></p> <p>[[50 - 100] %]</p> <p><i>Include bracketed provision and select either #1 or #2 if the Copayment is waived.</i></p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit.]</p> <p>[100% for the first [#] visits in a year; [50 - 90] % for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; [50 - 90] % for any subsequent visits in that year]</p> <p><i>Include for 2-tiered Copayment option.</i></p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] for any subsequent visits in that year]</p> <p><i>Include for 3-tiered Copayment option.</i></p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 700] for any subsequent visits in that year]</p> <p><i>Include for 4-tiered Copayment option.</i></p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 500] for the next [#] visits in a year; 100% after you pay a Copayment of \$[150 - 700] for any subsequent visits in that year]</p> <p><i>Include if plan design includes retrospective review of emergency services.</i></p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for a condition defined as an Emergency; 100% after you pay a Copayment of \$[50 - 650] per visit for a condition that does not</p>		

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	meet the definition of an Emergency]		
<b>[9.] [Hearing Aids]</b>			
<p><i>Include the limit selected by the group.</i></p> <p><i>Limit must be the same as annual limits selected for Durable Medical Equipment and Prosthetics, or \$5,000 per year if DME and Prosthetic limits exceed \$5,000 per year.</i></p> <p>[Limited to \$[500 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]</p>	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<b>[10.] Home Health Care</b>			
<p><i>Include if pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>2</sup><i>Include applicable reduction in Benefits.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before receiving services or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95]% of Eligible Expenses.]]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p> <p>[Limited to [40 - 200] visits per year to a maximum of \$[500 - 5,000] in Eligible Expenses per year.]</p> <p><i>Include when infusion administration only is not included in the limit.</i></p> <p>[This visit limit does not include any service which is billed only for the administration of intravenous infusion.]</p>	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 50] per visit]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<b>[11.] Hospice Care</b>			

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**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include if pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>2</sup><i>Include applicable reduction in Benefits.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95% of Eligible Expenses.]]</p>			
	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><b>[12.] Hospital - Inpatient Stay</b></p>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>2</sup><i>Include applicable reduction in Benefits.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[For a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95% of Eligible Expenses.]]</p>			
	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Inpatient Stay]		
<p><i>Include for groups that purchase infertility benefits.</i></p> <p><b>[13]. [Infertility Services]</b></p>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>2</sup><i>Select applicable penalty and include applicable reduction in Benefits.</i></p> <p align="center"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us as soon as the possibility of the need for Infertility Services arises. [<sup>1</sup>If you fail to notify us as required, [<sup>2</sup>Benefits will be reduced to [50 - 95]% of Eligible Expenses] [<sup>2</sup>you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p><i>Include the limit selected by the group.</i></p> <p><sup>1</sup><i>Include when benefits are provided for outpatient prescription drugs.</i></p> <p>[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [<sup>1</sup>This limit includes Benefits for infertility medications provided under <i>Outpatient Prescription Drugs</i> described further below.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]</p>	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><b>[14.] Lab, X-Ray and Diagnostics - Outpatient</b></p>			
<p><i>Include when pre-service notification is required for sleep studies.</i></p> <p><sup>1</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>2</sup><i>Include applicable reduction in Benefits.</i></p> <p align="center"><b>[Pre-service Notification Requirement]</b></p> <p>[For Benefits for sleep studies, you must notify us five business days before scheduled services are received. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95]% of Eligible Expenses.]]</p>			

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**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<b>International Benefits</b> [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per service]	[Yes] [No]	[Yes] [No]
<b>[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>			
<p><i>Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine.</i></p> <p><sup>1</sup><i>Include when penalty for non-notification applies.</i></p> <p><sup>2</sup><i>Include applicable reduction in Benefits.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95]% of Eligible Expenses.]]</p>			
	<b>International Benefits</b> [[50 - 100]%] [100% after you pay a Copayment of \$[25 - 500] per service]	[Yes] [No]	[Yes] [No]
<p><i>Include for groups that purchase mental health benefits.</i></p> <p><b>[16.] [Mental Health Services]</b></p>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when penalty for failure to notify applies.</i></p> <p><sup>2</sup><i>Include applicable percentage.</i></p> <p style="text-align: center;"><b>[Pre-Service Notification Requirement]</b></p> <p>[For a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>[In addition, you must notify us before the following services are received: intensive outpatient treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment</p>			

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**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
provided in your home].]			
[ <sup>1</sup> If you fail to notify us as required, Benefits will be reduced to [ <sup>2</sup> 50 - 95]% of Eligible Expenses.]]			
	<p><b><i>[International Benefits]</i></b></p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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Please refer to **Section 1: Covered Health Services** of the **Certificate** for coverage details that apply to each of the Benefit categories listed below.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include for groups that purchase mental health benefits.</i></p> <p><b>[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]</b></p>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when penalty for failure to notify applies.</i></p> <p><sup>2</sup><i>Include applicable percentage.</i></p> <p style="text-align: center;"><b>[Pre-Service Notification Requirement]</b></p> <p>[For a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>[In addition, you must notify us before the following services are received: intensive outpatient treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; [outpatient treatment provided in your home]; Applied Behavioral Analysis].]</p> <p>[<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95]% of Eligible Expenses.]]</p>			
	<p><b>[International Benefits]</b></p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Inpatient Stay]  [Outpatient]  [[50 - 100]%]  [100% after you pay a Copayment of \$[5 - 100] per visit]  [100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]  [100% for visits for medication management]	[Yes] [No]	[Yes] [No]  [Yes, when Benefits are subject to Coinsurance]
<i>Include for groups that purchase benefits for obesity surgery.</i>  <b>[18.] [Obesity Surgery]</b>			
<i>Include when pre-service notification is required.</i> <sup>1</sup> <i>Include when non-notification penalty applies.</i> <sup>2</sup> <i>Include applicable Benefit level.</i>  <b>[Pre-service Notification Requirement]</b>  [You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. [If you fail to notify us as required, Benefits will be reduced to [250 - 95]% of Eligible Expenses.]]  <b>[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]</b>			
<sup>1</sup> <i>Insert the limit selected by the group.</i>  [Limited to \$[140,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]	<b>[International Benefits]</b>  [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 <i>Schedule of Benefits</i> .]		
<i>Include if group purchases benefits for</i>			

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

Please refer to **Section 1: Covered Health Services** of the **Certificate** for coverage details that apply to each of the Benefit categories listed below.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>ostomy supplies.</i></p> <p><b>[19.] [Ostomy Supplies]</b></p>			
<p><i>Include the limit selected by the group.</i> [Limited to \$[500 - 25,000] per year.]</p>	<p><b>[International Benefits]</b> [[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><b>[20.] Pharmaceutical Products - Outpatient</b></p>			
<p><i>Include when notification is required for IV infusions.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include applicable reduction in Benefits.</i></p>			
<p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95]% of Eligible Expenses.]]</p>			
<p><i>Include when notification is required for select Pharmaceutical Products.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include applicable reduction in Benefits.</i></p>			
<p>[You must notify us five business days before certain pharmaceutical products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95]% of Eligible Expenses.] You may determine whether a particular Pharmaceutical Product requires notification through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
	<p><b>International Benefits</b> [[50 - 100]%) [100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p><i>Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.</i></p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
<b>[21.] Physician Fees for Surgical and Medical Services</b>			
	<b>International Benefits</b> [50 - 100]%	[Yes] [No]	[Yes] [No]
<b>[22.] Physician's Office Services - Sickness and Injury</b>			
	<b>International Benefits</b> [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Specialist Physician office visit]  [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]  [100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]  [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]		
<b>[23.] Pregnancy - Maternity Services</b>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include applicable Benefit level.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. <sup>1</sup>If you fail to notify us as required, Benefits will be reduced to <sup>2</sup>[50 - 95]% of Eligible Expenses.]</p> <p><b>[It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.]</b></p>			
<b>International Benefits</b>			

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><sup>1</sup>Include when an annual deductible applies.  <sup>2</sup>Include when services in the Physician's office are subject to a Copayment.</p> <p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [<sup>1</sup>except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [<sup>2</sup>For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]</p>			
<b>[24.] Preventive Care Services</b>			
<b>Physician office services</b>	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<b>Lab, X-ray or other preventive tests:</b>	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of \$[5 - 100] per service]		
<p><i>Include when group purchases benefits for prosthetic devices.</i></p> <p><b>[25.] [Prosthetic Devices]</b></p>			
<p><i>Include if notification is required.</i></p> <p><sup>1</sup>Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.</p> <p><sup>2</sup>Include when non-notification penalty applies.</p> <p><sup>3</sup>Include applicable reduction in Benefits or no Benefits.</p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us before obtaining prosthetic devices [<sup>1</sup>that exceed \$[1,000 - 5,000] in cost per device]. [<sup>2</sup>If you fail to notify us as required, [<sup>3</sup>Benefits will be reduced to [50 - 95]% of Eligible Expenses] [<sup>3</sup>you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p><i>Include the limit selected by the group.</i></p> <p><sup>1</sup>Include either option as standard.</p> <p>[<sup>1</sup>Limited to \$[2,500 - 100,000] per year. Benefits are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].]</p> <p>[<sup>1</sup>Limited per year as follows:</p> <ul style="list-style-type: none"> <li>• A maximum of \$[10,000 - 30,000] per body part for each arm, leg, hand or foot.</li> <li>• A maximum of \$[5,000 - 15,000] per body part for each eye, ear, nose, face or breast.</li> </ul> <p>These limits include repair. Benefits for replacement are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].]</p> <p><i>Always include statement below except when prosthetics are not limited.</i></p> <p>[Once this limit is reached, Benefits</p>	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

Please refer to **Section 1: Covered Health Services** of the **Certificate** for coverage details that apply to each of the Benefit categories listed below.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
continue to be available for items required by the <i>Women's Health and Cancer Rights Act of 1998</i> .]			
<b>[26.] Reconstructive Procedures</b>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include applicable Benefit level.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95] % of Eligible Expenses.]]</p>			
	<p><b>International Benefits</b></p> <p>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 <i>Schedule of Benefits</i>.</p> <p><i>Include when group does not purchase benefits for prosthetic devices.</i></p> <p><sup>1</sup><i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p><sup>2</sup><i>Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100] % of Eligible Expenses [<sup>1</sup>and Benefits [are] [are not] subject to payment of the Annual Deductible]. [<sup>2</sup>Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
<p><i>Include entire section when rehabilitation services benefit is sold.</i></p> <p><sup>1</sup><i>Include when Manipulative Treatment benefits are sold.</i></p> <p><b>[27.] [Rehabilitation Services - Outpatient Therapy [<sup>1</sup>and Manipulative Treatment]]</b></p>			
<i>Include when notification is required for any rehabilitation service.</i>			

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><sup>1</sup>Include when non-notification penalty applies.  <sup>2</sup>Include applicable Benefit level.</p>			
<p><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy] or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95] % of Eligible Expenses.]]</p>			
<p><i>Include when per therapy limits apply.</i>  <sup>1</sup>Include when Manipulative Treatment benefits are sold.  <sup>2</sup>Include when vision therapy benefits are sold.</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> <li>• [10-100] visits of physical therapy.</li> <li>• [10-100] visits of occupational therapy.</li> <li>• [<sup>1</sup>[10-100] visits of Manipulative Treatment.]</li> <li>• [10-100] visits of speech therapy.</li> <li>• [10-100] visits of pulmonary rehabilitation therapy.</li> <li>• [10-100] visits of cardiac rehabilitation therapy.</li> <li>• [10-100] visits of post-cochlear implant aural therapy.</li> <li>• [<sup>2</sup>[10-100] visits of vision therapy.]]</li> </ul> <p><i>Include when combined therapy visit limits apply.</i>  <sup>1</sup>Include when Manipulative Treatment benefits are sold and included in the combined limit. If they are sold but not</p>	<p><b>[International Benefits]</b>  [[50 - 100] %]  [100% after you pay a Copayment of \$[5 - 75] per visit]  [100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90] % for any subsequent visits in that year]</p>	<p>[Yes] [No]  [Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]  [Yes, when Benefits are subject to Coinsurance]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>included in the combined limit, they should be stated in the above separate limits.</i></p> <p><sup>2</sup><i>Include when vision therapy benefits are sold.</i></p> <p>[Any combination of physical therapy, occupational therapy, [<sup>1</sup>Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [<sup>2</sup>and vision therapy] is limited to [10 - 160] visits per year.]</p>			
<p><b>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</b></p>			
<p><i>Include when notification is required for scopic procedures.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include applicable Benefit level.</i></p>			
<p align="center"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95]% of Eligible Expenses.]]</p>			
	<p><b>International Benefits</b></p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><b>[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b></p>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include applicable Benefit level.</i></p>			
<p align="center"><b>[Pre-service Notification Requirement]</b></p> <p>[For a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. [<sup>1</sup>If you fail to notify us as required, Benefits will be</p>			

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
reduced to [ <sup>2</sup> 50 - 95] % of Eligible Expenses.]]			
<p><i>Include limit selected by group.</i></p> <p>[Limited to [40 - 180] days per year.]</p>	<p><b>International Benefits</b></p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p><i>Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.</i></p> <p>[<sup>1</sup>100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[<sup>1</sup>100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 5,000] per Inpatient Stay]</p> <p><i>Variable #1 can be used only with options numbered #1 above.</i></p> <p>[<sup>1</sup>If you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility, any combination of Copayments required for the Inpatient Stay in a Hospital and the Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility will apply to the stated</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	maximum Copayment per Inpatient Stay.  [No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.]		
<i>Include for groups that purchase substance use disorder benefits.</i>  <b>[30.] [Substance Use Disorder Services]</b>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when penalty for failure to notify applies.</i></p> <p><sup>2</sup><i>Include applicable percentage.</i></p> <p align="center"><b>[Pre-Service Notification Requirement]</b></p> <p>[For a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>[In addition, you must notify us before the following services are received: intensive outpatient treatment programs; psychological testing; [outpatient treatment of opioid dependence; ]extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management[; outpatient treatment provided in your home].]</p> <p>[<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95]% of Eligible Expenses.]]</p>			
	<b><i>[International Benefits]</i></b>  <i>[Inpatient]</i>  [[50 - 100]%]  [100% after you pay a Copayment of \$[100 - 1,000] per day]  [100% after you pay a Copayment	[Yes] [No]	[Yes] [No]

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>of \$[100 - 2,000] per Inpatient Stay</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

**[31.] Surgery - Outpatient**

*Include when pre-service notification is required.*

<sup>1</sup>*Include when non-notification penalty applies.*

<sup>2</sup>*Include applicable Benefit level.*

**[Pre-service Notification Requirement]**

[[For all outpatient surgeries] [For [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]] you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95] % of Eligible Expenses.]

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p><b>International Benefits</b></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100%after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]]</p>	[Yes] [No]	[Yes] [No]
<p><i>Include when group purchases TMJ benefit.</i></p> <p><b>[32.] [Temporomandibular Joint Services]</b></p>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include applicable Benefit level.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>1</sup>50 - 95] % of Eligible Expenses.]]</p> <p><i>Always include this statement when TMJ benefits are sold.</i></p> <p>[Note that for Covered Health Services provided outside the <i>United States</i>, Benefits for surgical services also include TMJ implants approved by the appropriate governmental authority only when all other treatment has failed.]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to \$[1,000 - 20,000] per year.]</p>	<p><b>[International]</b></p> <p>[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 <i>Schedule of Benefits</i>.]</p>		
<p><b>[33.] Therapeutic Treatments - Outpatient</b></p>			
<p><i>Include when pre-service notification is required.</i></p>			

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><sup>1</sup>Include when non-notification penalty applies.  <sup>2</sup>Include applicable Benefit level.</p>			
<p><b>[Pre-service Notification Requirement]</b></p> <p>[[For all outpatient therapeutic services] [For the following outpatient therapeutic services] you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require notification: [dialysis] [,] [and] chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [hyperbaric oxygen therapy].] [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95%] of Eligible Expenses.]]</p>			
	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><b>[34.] Transplantation Services</b></p>			
<p>Include when pre-service notification is required.  <sup>1</sup>Include when non-notification penalty applies.  <sup>2</sup>Include applicable Benefit level.</p>			
<p>[You must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). [<sup>1</sup>If you fail to notify us as required, Benefits will be reduced to [<sup>2</sup>50 - 95%] of Eligible Expenses.]]</p>			
	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>[35.] Urgent Care Center Services</b>			
<p><i>Include when urgent care services are limited and insert the limit selected by the group.</i></p> <p>[Limited to [2 - 10] visits per year.]</p>	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<p><i>Include when group purchases benefits for vision exams.</i></p> <p><b>[36.] [Vision Examinations]</b></p>			
<p>[Limited to [1 exam] [[2-3] exams] per year.]</p> <p>[Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]</p>	<p><b>International Benefits</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of [\$5 - 75] per visit]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><i>Include when group purchases benefits for wigs.</i></p> <p><b>[37.] [Wigs]</b></p>			

**[When Benefit limits apply, the limit refers to any combination of International Benefits as described in this Rider and Benefits provided within the United States as described in the Certificate, Schedule of Benefits and any attached Riders and Amendments.]**

**Please refer to Section 1: Covered Health Services of the Certificate for coverage details that apply to each of the Benefit categories listed below.**

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>Include the limit selected by the group.</i> [Limited to \$[100 - 1,000] per year.] [Limited to \$[100 - 5,000] every [24 - 36] months.]	<b>[International Benefits]</b> [[50 - 100]%]	[Yes] [No]	[Yes] [No]

*Include paragraph below when benefits are available for any of the following benefits: Culturally-Based Services, Emergency Evacuation, Medical Repatriation, Outpatient Prescription Drugs or Repatriation of Remains.*

[In addition to the Covered Health Services described in the Certificate in Section 1: Covered Health Services and described above, International Benefits are available for the Covered Health Services described below.]

*Include when plan provides benefits for Culturally-Based Services.*

**[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. Benefits for culturally-based services are available only when we determine that the service or supply meets the following criteria:

- It is care or treatment that is as likely to produce a significant positive outcome as (and no more likely to produce a negative outcome than) any alternative service or supply, both as to the Sickness or Injury involved and the Covered Person's overall health condition.
- It is a diagnostic procedure indicated by the health status of the person that is as likely to result in information that could affect the course of treatment as (and no more likely to produce a negative outcome than) any alternative service or supply, both as to the Sickness or Injury involved and the Covered Person's overall health condition.
- It is diagnosis, care and treatment that is no more costly than any alternative services or supply to meet the above tests, taking into account all health expenses incurred in connection with the service or supply.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>[Culturally-Based Services]</b>			
<i>Include when pre-service notification is required.</i> <sup>1</sup> <i>Include when non-notification penalty applies.</i> <sup>2</sup> <i>Include applicable Benefit level.</i>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>[Pre-service Notification Requirement]</b> [You must notify us five business days prior to receiving services. [ <sup>1</sup> If you don't notify us, Benefits will be reduced to [ <sup>1</sup> 50 - 95] % of Eligible Expenses].]			
	<b>[International Benefits]</b> [50 - 100] %	[Yes] [No]	[Yes] [No]

*Include when plan provides benefits for emergency evacuation.*

### [Emergency Evacuation]

[If you suffer a Sickness or Injury and adequate medical facilities are not available locally in the opinion of our *Medical Director* or the *Medical Director* of our affiliate or authorized vendor under our direction, we will provide emergency evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. Covered Health Services include arranging and providing for transportation and related medical services (including cost of medical escort) and medical supplies necessarily incurred in connection with the emergency evacuation.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>[Emergency Evacuation]</b>			
<i>Include when pre-service notification is required.</i> <sup>1</sup> <i>Include when non-notification penalty applies.</i> <sup>2</sup> <i>Include applicable Benefit level.</i>			
<b>[Pre-service Notification Requirement]</b> [You must notify us as soon as the possibility of Emergency Evacuation arises. [ <sup>1</sup> If you don't notify us, Benefits will be reduced to [ <sup>2</sup> 50 - 95] % of Eligible Expenses].]			
	<b>[International Benefits]</b> [[50 - 100] %] [100% after you pay a Copayment of \$[25 - 300] per transport] [100% after you pay a Copayment of \$[300 - 1,000] per day] [100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]	[Yes] [No]	[Yes] [No]

*Include when plan provides benefits for medical repatriation.*

**[Medical Repatriation]**

[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 medically necessary, we will transport you back to your permanent place of residence for further medical treatment or to recover. Covered Health 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.

Benefits are available for medical repatriation, provided that both of the following apply:

- The treatment required is a Covered Health Service.
- The treatment is recommended by your Physician.

You must provide us with any information or proof that we may reasonably request.

Benefits for medical repatriation are only available if all arrangements for your repatriation are approved in advance and arranged by us. Physicians from our appointed representatives will discuss all relevant factors with your own Physician before authorizing payment for repatriation.

<sup>1</sup>*Include when plan provides benefits for companion travel.*

<sup>2</sup>*Include when plan provides benefits for domestic partners.*

<sup>3</sup>*Include when companion travel benefits are limited.*

[<sup>1</sup>Benefits are also provided for the reasonable travel costs for your relative [<sup>2</sup>or your Domestic Partner] to accompany you if authorized in advance of the repatriation [<sup>3</sup>and are limited as stated in the *Schedule of Benefits*.]

<sup>1</sup>*Include when plan provides benefits for companion travel.*

We will pay for you [<sup>1</sup>and the person accompanying you] to return to where you were repatriated from. We must approve in advance all arrangements for your return and you must make the return journey within 14 days of the end of the treatment you were repatriated for. We will pay either of the following, whichever is the lesser amount:

- The actual cost you incur for the journey.
- The cost of a scheduled return economy class journey by the most direct route available.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>[Medical Repatriation]</b>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include and insert applicable reduction in Benefits if benefit reduction applies.</i></p> <p><sup>3</sup><i>Include when Benefits will not be paid.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us to obtain Benefits for Medical Repatriation. [<sup>1</sup>If you don't notify us, [<sup>2</sup>Benefits will be reduced to [50 - 95]% of Eligible Expenses] [<sup>3</sup>you will be responsible for paying all charges and no Benefits will be paid].]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><sup>1</sup>Include appropriate number; include "s" if more than one.</p> <p>[Limited to [1 one - five] medical repatriation[1s] per Sickness or Injury.]</p> <p><i>Include when companion travel benefits are limited and include the applicable dollar and day limit; include "s" if more than one day.</i></p> <p>[Benefits are provided for an allowance of up to \$[1 - 1,000] per day for up to [one - ten] [11 - 60] day[s] towards the living expenses incurred by the person accompanying you.]</p>	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 300] per transport]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

*Include when outpatient prescription drugs are covered under the medical plan.*

### [Outpatient Prescription Drugs]

[Outpatient prescription drugs that are prescribed for you by your Physician to treat a Sickness or Injury for which Benefits are provided as described in this *Certificate*. Benefits for outpatient prescription drug products are available when the outpatient prescription drug product meets the definition of a Covered Health Service. Benefits are not available for over the counter drugs or other drugs or treatments available without a prescription. Prescriptions must be paid for out-of-pocket by the Covered Person and submitted to us for reimbursement.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include when outpatient prescription drugs are covered under the medical plan.</i></p> <p><b>[Outpatient Prescription Drugs]</b></p>			
	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[1 - 200] per prescription order or refill]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

### [Repatriation of Remains]

[In the event of your death, we or our affiliate or authorized vendor will render assistance and provide for the return of mortal remains. Services include:

- Location of a sending funeral home.

- Transportation of the body from the site of death to the sending funeral home.
- Preparation of the remains for either burial or cremation.
- Transportation of the remains from the funeral home to the airport.
- Minimally necessary casket or air tray for transport.
- Coordination of consular services (in the case of death overseas).
- Procuring death certificates.
- Transport of the remains from the airport to the receiving funeral home.

Other services that may be performed in conjunction with those listed above include making travel arrangements for any traveling companions and identification and/or notification of next-of-kin.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include when benefits are provided for Repatriation of Remains.</i></p> <p><b>[Repatriation of Remains]</b></p>			
<p><i>Include when pre-service notification is required.</i></p> <p><sup>1</sup><i>Include when non-notification penalty applies.</i></p> <p><sup>2</sup><i>Include and insert applicable reduction in Benefits if benefit reduction applies.</i></p> <p><sup>3</sup><i>Include when Benefits will not be paid.</i></p> <p style="text-align: center;"><b>[Pre-service Notification Requirement]</b></p> <p>[You must notify us to obtain Benefits for Repatriation of Remains. [<sup>1</sup>If you don't notify us, [<sup>2</sup>Benefits will be reduced to [50 - 95]% of Eligible Expenses] [<sup>3</sup>you will be responsible for paying all charges and no Benefits will be paid].]</p>			
	<p><b>[International Benefits]</b></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 - 300] per transport]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

## Eligible Expenses for International Benefits

Eligible Expenses for International Benefits are the amount we determine that we will pay for Benefits described in this Rider. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines.

When Covered Health Services are received from a provider outside the *United States*, Eligible Expenses are determined, at our discretion, based on the following:

- Any applicable contracted or negotiated fee(s) with that provider.
- If the fees are not contracted or negotiated with the provider, then the Eligible Expenses will be representative of the average and prevailing charge for the same health service in the same or similar geographic communities where the Covered Health Service is rendered.
- In all circumstances, the charges shall not exceed the fees that the provider would charge any other party for the same health service.

## Exclusions and Limitations for International Benefits

***Exclusions and limitations stated in the Certificate under Section 2: Exclusions and Limitations apply to International Benefits described in this Rider except as modified below.***

International Benefits are provided only to the extent that provision of insurance is permitted under the applicable *United States* economic or trade sanctions, and claims submitted under the Policy could be delayed or denied if the required license or other authorization cannot be obtained from the *United States* government.

*Include when plan provides benefits for Culturally-Based Services.*

***[The following exception to the exclusion for Alternative Treatments applies to International Benefits:]***

### **[A.] [Alternative Treatments]**

[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* above.]

*Include when plan provides International benefits for Outpatient Prescription Drugs.*

***[The following exclusions for Drugs apply to International Benefits:]***

### **[D.] [Drugs]**

- [1.] [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.]
- [2.] [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.]
- [3.] [Over-the-counter drugs and treatments.]
- [4.] [Growth hormone therapy.]

***The following exclusions for Services Provided under another Plan apply to International Benefits:***

### **[Q.] Services Provided under another Plan**

- [1.] 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, no-fault auto insurance, or similar legislation.

<sup>1</sup>*Include when group purchases MH benefits.* <sup>2</sup>*Include when group does not purchase MH benefits.*

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 [1Mental Illness] [2mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.

- [2.] Health services provided while you are covered under a separate policy issued through your Enrolling Group as stipulated by a foreign governmental requirement.

<sup>1</sup>Include when more than one exclusion will be listed.

<sup>2</sup>Include when only one exclusion will be listed.

**The following exclusion<sup>1</sup>s for Travel <sup>2</sup>applies] <sup>1</sup>apply] to International Benefits:**

## **[T.] Travel**

- [1.] Health services provided in a foreign country, except for those services specifically described as Covered Health Services in this Rider.

*Include #2 when plan provides benefits for any service described above for emergency evacuation, medical repatriation or repatriation of remains.*

<sup>1</sup>Include and select the services that are covered. Include "and" and "comma" appropriately.

- [2.] [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. [<sup>1</sup>This exclusion does not apply to [Emergency Evacuation] [,] [and] [Medical Repatriation] [and] [Repatriation of Remains] for which Benefits are described above.]]

*Include when International Benefits are available only within the country or geographic region to which the Expatriate has been sent on assignment. <sup>1</sup>Include when International Benefits are also available to Key Local Nationals. <sup>2</sup>Include when this limit applies also to Enrolled Dependents. <sup>3</sup>Select either country or geographic region.*

- [3.] [Health services provided to the [<sup>1</sup>Expatriate] Subscriber [<sup>2</sup>and to their Enrolled Dependents] outside the Expatriate's home country or outside the [<sup>3</sup>country] [<sup>3</sup>geographic region] to which the Expatriate has been sent on assignment, unless required as Emergency Health Services.]

*Include when International Benefits are not available for Enrolled Dependents who do not reside with the Expatriate in the country to which the Expatriate has been sent on assignment. Include when International Benefits are also available to Key Local Nationals.. <sup>2</sup>Select either country or geographic region.*

- [4.] [Health services for Enrolled Dependents of an [<sup>1</sup>Expatriate] Subscriber provided outside of an Enrolled Dependent's home country when the Enrolled Dependent does not reside with the Expatriate in the [<sup>2</sup>country] [<sup>2</sup>geographic region] to which the Expatriate has been sent on assignment, unless required for Emergency Health Services.]

*Include when International Benefits are available to Key Local National's. Include when International Benefits are available to Enrolled Dependents.]*

- [5.] [Health services provided to Key Local National Subscribers [<sup>1</sup>and to their Enrolled Dependents] outside the Key Local National's home country, unless required as Emergency Health Services.]

Include when the Enrolling Group chooses to exclude coverage by country or geographic region.

**[The following exclusion under All Other Exclusions applies to International Benefits:]**

## **[W.] [All Other Exclusions]**

*Include and complete when the Enrolling Group chooses to exclude coverage by country or geographic region.*

- [11.] [Health services provided in the following [countries] [geographic regions]:

- [North Korea.]
- [Cuba.]
- [\_\_\_\_\_.]

[12.] Health services when claims payment and/or coverage is prohibited by applicable law.

*Include introductory sentence and provision(s) below when claims payment restrictions apply.*

***[The following provision regarding claims payment applies to International Benefits:]***

## **[Claims]**

### **[How Claims will be Paid]**

[We make all payments, in our discretion, in one of the following ways:

- In the currency of the invoices relating to the claim.
- In U.S. dollars.
- In the currency of your choice.

It is your responsibility to pay any charges which are not eligible for payment under the Policy.]

### **[How Exchange Rates will be Calculated]**

[If it is necessary to make a conversion from one currency to another, we will use the mid-market exchange rate in effect on the date of service.]

## **General Legal Provisions**

***The following provision regarding Defense Base Act (DBA) coverage applies to International Benefits:***

### **Defense Base Act (DBA) Coverage not Affected**

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by the *Defense Base Act*.

## **Defined Terms**

***For [Global Solutions], the following definitions apply:***

*Include definition when International Benefits are available to Enrolled Dependents.*

<sup>1</sup>*Include bracketed text if group purchases Domestic Partner coverage.*

**[Dependent** - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. [<sup>1</sup>All references to the spouse of a Subscriber shall include a Domestic Partner.] The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

*Include if group chooses to include the parents of the Subscriber as Dependents. <sup>1</sup>Include if group chooses to include the grandparents of the Subscriber as Dependents. <sup>2</sup>Include if group chooses to include the parents of the Subscriber's spouse as Dependents.*

[The definition of Dependent includes parents [<sup>1</sup>and grandparents] of the Subscriber [<sup>2</sup>or the Subscriber's spouse].]

*Include if group chooses to allow a broader category of sponsored dependents.*

[The definition of Dependent includes such other sponsored Dependents as agreed upon by us and the Enrolling Group.]

The definition of Dependent is subject to the following conditions and limitations:

<sup>1</sup>*Modify age as appropriate to accommodate group decision.*

- A Dependent includes any child listed above under [<sup>1</sup>26-30] years of age.
- A Dependent includes an unmarried dependent child age [<sup>1</sup>26 - 30] or older who is or becomes disabled and dependent upon the Subscriber.

*Include paragraph below when group intends to allow coverage for a dependent child until the last day of the year in which he/she reaches the limiting age.*

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age [<sup>1</sup>26 - 30].]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

*Include when the group does not elect double coverage.*

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

<sup>1</sup>*Include when International Benefits are available to Key Local Nationals.*

**Eligible Person** - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must be an Expatriate [<sup>1</sup>or a Key Local National].

**Expatriate** - an Eligible Person who is sent on assignment outside his or her own country, as agreed upon between the Enrolling Group and us.

**Experimental or Investigational Service(s)** - medical, surgical, diagnostic, psychiatric, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- When medical, surgical, diagnostic, psychiatric, substance use disorder and other health care services, technologies, supplies, treatments, procedures, drug therapies, medications and devices are provided outside the *United States*, the determination of status as an Experimental or Investigational Service will be made in our reasonable judgment based on clinical standards that apply within the country in which the service is provided and relevant regulatory review processes and requirements.

*[Include when the group purchases benefits for clinical trials.]*

- [Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.]
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

For services provided outside the *United States*, if the service is one that requires review and approval by a governmental agency, then the service must be approved by that agency.

**International Benefits** - this is the description of how Benefits are paid for Covered Health Services provided by or under the direction of a Physician outside the *United States*.

*[Include when International Benefits are available to Key Local Nationals.]*

**[Key Local National** - an Eligible Person that works and resides within their country of citizenship and who the Enrolling Group has determined is eligible under the Policy as a condition of their employment and/or because they are essential to the management of their work country's operation.]

**Pharmaceutical Product(s)** - for Pharmaceutical Products provided outside the *United States*, these are prescription pharmaceutical products that are reviewed and approved by the applicable governmental agency and administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

**Unproven Service(s)** - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [[www.myuhc.com](http://www.myuhc.com)].

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - For services provided outside the *United States*, if the service is one that requires review and approval by a governmental agency, then the service must be approved by that agency.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

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(Name and Title)

SERFF Tracking Number: INCS-127844361 State: Arkansas  
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 50329  
 Company Tracking Number: GLBSOL.09R2.AR  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002C Large Group Only - Other  
 Product Name: UHC Global Solutions Rider  
 Project Name/Number: UHC Global Solutions Rider/UHC GLBSOL.09R2

**Rate Information**

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:**

Neutral

**Overall Percentage of Last Rate Revision:**

%

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

**Company Rate Information**

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
UnitedHealthcare Insurance Company	New Product	%	%				%	%

SERFF Tracking Number: INCS-127844361 State: Arkansas  
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Product Name: UHC Global Solutions Rider  
Project Name/Number: UHC Global Solutions Rider/UHC GLBSOL.09R2

## Rate Review Details

### COMPANY:

Company Name: UnitedHealthcare Insurance Company  
HHS Issuer Id: 94968  
Product Names: Global Solutions Rider  
Trend Factors:

### FORMS:

New Policy Forms: Rider Form GLBSOL.09R1.KS  
Affected Forms:  
Other Affected Forms:

### REQUESTED RATE CHANGE

#### INFORMATION:

Change Period: Annual  
Member Months: 0  
Benefit Change: None  
Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

#### PRIOR RATE:

Total Earned Premium:  
Total Incurred Claims:  
Annual \$: Min: Max: Avg:

#### REQUESTED RATE:

Projected Earned Premium: 0.00  
Projected Incurred Claims: 0.00  
Annual \$: Min: 0.00 Max: 0.00 Avg: 0.00

SERFF Tracking Number: INCS-127844361 State: Arkansas  
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 50329  
 Company Tracking Number: GLBSOL.09R2.AR  
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 Product Name: UHC Global Solutions Rider  
 Project Name/Number: UHC Global Solutions Rider/UHC GLBSOL.09R2

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	11/30/2011
<b>Comments:</b>		
<b>Attachment:</b> ARKANSAS CERTIFICATE OF COMPLIANCE R2.pdf		

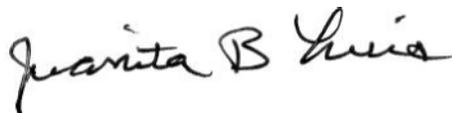
	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	11/30/2011
<b>Comments:</b> The employer application to be used with this product is form LG.ER.07.AR 10/07, approved 11/20/2007 under file number UHLC-125350434.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	11/30/2011
<b>Bypass Reason:</b> NA - PPACA IS NOT APPLICABLE TO RIDER		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> AUTHORIZATION LETTER	Approved-Closed	11/30/2011
<b>Comments:</b>		
<b>Attachment:</b> ICS Authorization UCH 2011.pdf		

ARKANSAS CERTIFICATE OF COMPLIANCE

UnitedHealthcare Insurance Company hereby certifies that the policy forms listed below are in compliance with all of the requirements of Arkansas Insurance Department Rule and Regulation 19. The benefits/coverage provided by the forms listed below are available to, and will be administered, in a non-discriminatory manner.



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(Signature)

Assistant Secretary

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(Title)

11/21/2011

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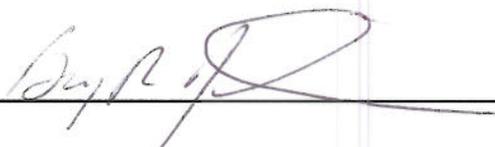
(Date)

Policy Form Numbers: GBL SOL.09R2.AR

January 13, 2011

COMPANY: UnitedHealthcare Insurance Company  
NAIC Number: 79413  
FEIN Number: 36-2739571

Please accept this letter as authorization for Innovative Compliance Solutions, LLC to act as our agent for submission of policy forms and rate information and to perform each and every act necessary in connection with such submission on behalf of UnitedHealthcare Insurance Company.

SIGNATURE:  \_\_\_\_\_

SIGNED BY: Bryan R. Johnson

TITLE: Vice President

UnitedHealthcare Insurance Company