

SERFF Tracking Number: INCS-127207782 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 49133
Company Tracking Number: BENSUM.GSCPON.I.09
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: UHIC 2011 Benefit Summary
Project Name/Number: UHIC 2011 Benefit Summary/UHIC 2011 Benefit Summary

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: UHIC 2011 Benefit Summary SERFF Tr Num: INCS-127207782 State: Arkansas
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 49133
Closed

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: State Status: Approved-Closed
BENSUM.GSCPON.I.09

Filing Type: Form

Reviewer(s): Rosalind Minor
Author: Renee Weaver Disposition Date: 06/30/2011
Date Submitted: 06/24/2011 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: UHIC 2011 Benefit Summary
Project Number: UHIC 2011 Benefit Summary
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: does not require
approval

Explanation for Combination/Other:

Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 06/30/2011

State Status Changed: 06/30/2011

Created By: Renee Weaver

Deemer Date:

Submitted By: Renee Weaver

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Re: UnitedHealthcare Insurance Company

NAIC No. 79413

Form: BENSUM.GSCPON.I.09.AR

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

SERFF Tracking Number: INCS-127207782 State: Arkansas
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The enclosed Benefit Summary is being submitted for your review. This Benefit Summary is given to prospective large group customers for the purpose of describing the benefits available under our Global Solutions Choice Plus, Options PPO and Non-Differential PPO products.

This Benefit Summary is used with the Global Solutions Rider form GLBSOL.09R1.AR approved on January 18, 2011 under SERFF Tracking Number: INCS-126985070.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Renee Weaver
Innovative Compliance Solutions
Compliance Consultant

Ph: 763-323-8643
Fax: 763-712-8001
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

Filing Fees

SERFF Tracking Number: INCS-127207782 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$50.00	06/24/2011	49076321

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2011	06/30/2011

SERFF Tracking Number: INCS-127207782 *State:* Arkansas
Filing Company: UnitedHealthcare Insurance Company *State Tracking Number:* 49133
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Disposition

Disposition Date: 06/30/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: INCS-127207782 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes

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Form Schedule

Lead Form Number: BENSUM.GSCPON.I.09.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/30/2011 R	BENSUM.CO PON.I.09.A	Other	Benefit Summary	Initial			AR Global Solutions 2007 KA INS Medical PLUS _6 3 11.pdf



Benefit Summary

Arkansas Global Solutions – [[Choice Plus][Options PPO][Non-Differential PPO]]
[Plan Category Name] – [Plan Description] Plan [XX-X]

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

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

PLAN HIGHLIGHTS

Choice Plus and Options PPO network applications are identified as 'Network' Benefits.

Non-Differential PPO also known as 8080 are identified as 'U.S.' Benefits.

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
[Annual Deductible]		
[Individual Deductible][Single Coverage Deductible]	[International:][[\$0-15,000] per year][No Annual Deductible] [Network:][U.S.]:[\$0-15,000] per year][No Annual Deductible]	[\$0-15,000] per year][No Annual Deductible]
[Family Deductible][Family Coverage Deductible]	[International:][[\$0-45,000] per year][No Annual Deductible] [Network:][U.S.]:[\$0-45,000] per year][No Annual Deductible]	[\$0-45,000] per year][No Annual Deductible]
<ul style="list-style-type: none"> • [This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence Deductible must be met prior to and in addition to the Annual Deductible.] • [Member Copayments do [not] accumulate towards the Deductible.] • [No one in the family is eligible for Benefits until the family coverage Deductible is met.] • [All Individual Deductible amounts will count toward the Family Deductible, but an individual will not have to pay more than the Individual Deductible amount.] 		
[Out-of-Pocket Maximum]		
[Individual Out-of-Pocket Maximum][Single Coverage Out-of-Pocket Maximum]	[International:][[\$0-45,000] per year][No Out-of-Pocket Maximum] [Network:][U.S.]:[\$0-45,000] per year][No Out-of-Pocket Maximum]	[\$0-45,000] per year][No Out-of-Pocket Maximum]
[Family Out-of-Pocket Maximum][Family Coverage Out-of-Pocket Maximum]	[International:][[\$0-135,000] per year][No Out-of-Pocket Maximum] [Network:][U.S.]:[\$0-135,000] per year][No Out-of-Pocket Maximum]	[\$0-135,000] per year][No Out-of-Pocket Maximum]
<ul style="list-style-type: none"> • [The Out-of-Pocket Maximum [includes] [does not include] [the Annual Deductible] [and] [Per Occurrence Deductible].] • [If more than one person in a family is covered under the Policy, the [individual] [single coverage] Out-of-Pocket Maximum stated above does not apply.] • [Member Copayments do not accumulate towards the Out-of-Pocket Maximum.] • [All Individual Out-of-Pocket Maximum amounts will count toward the Family Out-of-Pocket Maximum, but an individual will not have to pay more than the Individual Out-of-Pocket Maximum amount.] 		

BENSUM.CPON.I.09.AR

Benefit Plan Coinsurance – The Amount We Pay

[International:][[50-100]% [after Deductible has been met] [Deductible does not apply]]

[Network:][U.S.:[[50-100]% [after Deductible has been met]] [Deductible does not apply]]

[[50-100]% [after Deductible has been met]]

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

[Plan Name]

Item #

[XXX-XXXX]

Rev. Date

[XX-XX]

[Benefit Accumulator]

[[Calendar][Policy] Year]

[PVY][PVN][Sep][Comb][Emb][Non-Emb][Request #]

UnitedHealthcare Insurance Company

PLAN HIGHLIGHTS**Types of Coverage**

[[International and U.S.] [Network] Benefits]

[Non-Network Benefits]

Maximum Policy Benefit

The maximum amount we will pay during the entire period of time you are enrolled under the Policy.

No Maximum Policy Benefit.

[Prescription Drug Benefits]

[Prescription drug benefits are shown under separate cover.]

Information on Benefit Limits

- The [Annual Deductible,] [and] [Out-of-Pocket Maximum] [and] [Benefit limits] are calculated on a [Policy][calendar] year basis.
- [All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.]
- [When Benefit limits apply, the limit refers to any combination of International, [Network] [and U.S.] [and Non-Network] Benefits unless specifically stated in the Benefit category.]

MOST COMMONLY USED BENEFITS**Types of Coverage**

[[International and U.S.] [Network] Benefits]

[Non-Network Benefits]

Physician's Office Services – Sickness and Injury

[Primary Physician Office Visit]

[International:][[50-100]% [after Deductible has been met]] [Deductible does not apply]]

[100% after you pay a \$[5-100] Copayment per visit]

[100% after you pay a Copayment of \$[5 – 75] per visit for a Primary Physician office visit or a \$[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 Specialist Physician office visit]

[[50-100]% [after Deductible has been met]]

[100% after you pay a \$[5-100] Copayment per visit]

[100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

[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

[Designated Network:[50-100]% [after Deductible has been met]][Deductible does not apply]]

[100% after you pay a \$[5-100] Copayment]

[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]

[100% after you pay a \$[5-100] Copayment per visit]

[100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

[100% after you pay a \$[5-75] Copayment per visit for a Primary Physician office visit or \$[5-100] Copayment per visit for a Specialist Physician office visit for the first [#] visits in a year; [50-90]% [after Deductible has been met] for any subsequent visits in that year]

[Specialist Physician Office Visit]

[International;][50-100]% [after Deductible has been met]][Deductible does not apply]]

[100% after you pay a \$[5-100] Copayment per visit]

[100% after you pay a Copayment of \$[5 – 75] per visit for a Primary Physician office visit or a \$[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 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

[[50-100]% [after Deductible has been met]]

[100% after you pay a \$[5-100] Copayment per visit]

[100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

visits in that year]

[Designated Network:[50-100]% [after Deductible has been met][Deductible does not apply]]

[100% after you pay a \$[5-100] Copayment]

[Network;][U.S.:][[50-100]% [after Deductible has been met][Deductible does not apply]]

[100% after you pay a \$[5-100] Copayment per visit]

[100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

[100% after you pay a \$[5-75] Copayment per visit for a Primary Physician office visit or \$[5-100] Copayment per visit for a Specialist Physician office visit for the first [#] visits in a year; [50-90]% [after Deductible has been met] for any subsequent visits in that year]

[In addition to the office visit Copayment stated in this section, the Copayments and any Deductible/Coinsurance for the following services apply when the Covered Health Service is performed in a Physician's office:

- [Lab, radiology/X-rays and other diagnostic services described under Lab, X-Ray and Diagnostics - Outpatient.]
- [Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.]
- [Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic.]
- [Outpatient surgery procedures described under Surgery - Outpatient.]
- [Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.]
- [Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]

Preventive Care Services

Covered Health Services include but are not limited to:

Primary Physician Office Visit

[International:] 100% Deductible does not apply
[Network;][U.S.:]100% Deductible does not apply

[Non-Network Benefits are not available except for children under the age of 19]
[100% after you pay a \$[5-100] Copayment per visit]
[[50-100]% [after Deductible has been met]]

Benefits are limited as follows for the [Network and Non-Network] [U.S.] Benefit:

Well baby and well child care includes, but not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years.

No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.

Specialist Physician Office Visit

[International:] 100% Deductible does not apply
[Network;][U.S.:]100% Deductible does not apply

Benefits are limited as follows for the [Network and Non-Network] [U.S.] Benefit:

Well baby and well child care includes, but not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years.

No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.

Lab, X-Ray or other preventive tests

[International:] 100% Deductible does not apply

Benefits are limited as follows for the [Network and Non-Network] [U.S.]

[Network;][U.S.]:100% Deductible does not apply

Benefit:

No deductible will be applicable to Network or non-Network

Prostate Cancer Screening.

MOST COMMONLY USED BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
Urgent Care Center Services	<p>[International;][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-150] Copayment per visit] [100% after you pay a Copayment of \$[5 – 150] per visit to a maximum Copayment of \$[5 – 5,000] per year] [100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a \$[5-150] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]</p>	<p>[[50-100]% [after Deductible has been met]] [100% after you pay a \$[5-150] Copayment per visit] [100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a \$[5-150] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]</p>
	<p>Network;][U.S.]:[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[5-150] Copayment per visit] [100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a \$[5-150] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]</p>	

[In addition to the Copayment stated in this section, the Copayments and any Deductible/Coinsurance for the following services apply when the Covered Health Service is performed at an Urgent Care Center:

- [Lab, radiology/X-rays and other diagnostic services described under Lab, X-Ray and Diagnostics - Outpatient.]
- [Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.]
- [Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and

Therapeutic.]

- [Outpatient surgery procedures described under Surgery - Outpatient.]
- [Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.]
- [Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]

Emergency Health Services - Outpatient

¹Include for 2-tier Copayment option

²Include for 3-tier Copayment option

³Include for 4-tier Copayment option

[International:][100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

[¹100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[50-650] Copayment per visit [¹for any subsequent visits in that year][²for the next [#] visits in a year][²; 100% after you pay a \$[100-700] Copayment per visit for any subsequent visits in that year]

[³100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[50-650] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[100-500] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[150-700] Copayment per visit for any subsequent visits in that year]

[Network:][U.S.:][[50-100]% [after Deductible has been met][Deductible does not apply]]

[100% after you pay a \$[5- 500] Copayment per visit]. [If you are admitted as an inpatient to a Network Hospital [directly from the Emergency room] [within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]]

[100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

[100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

[¹100% after you pay a \$[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a \$[50-650] Copayment per visit [¹for any subsequent visits in that year][²for the next [#] visits in a year][²; 100% after you pay a \$[100-700] Copayment per visit for any subsequent visits in that year]

[³100% after you pay a \$[5-500] Copayment per visit for the first [#] visits

[[50-100]% [after Network Deductible has been met][Deductible does not apply]]

[100% after you pay a \$[5-300] Copayment per visit]

in a year; 100% after you pay a \$[50-650] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[100-500] Copayment per visit for the next [#] visits in a year; 100% after you pay a \$[150-700] Copayment per visit for any subsequent visits in that year]]
 [For [Network][U.S.] Benefits; Pre-service Notification is required if results in an Inpatient Stay.]

[Pre-service Notification is required if results in an Inpatient Stay.]

Hospital – Inpatient Stay

[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]]
 [100% after you pay a \$[100-1,000] Copayment per day]
 [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay]
 [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-10,000] Copayment per Inpatient Stay]

[[50-100]% [after Deductible has been met]]
 [100% after you pay a \$[100-1,000] Copayment per day]
 [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay]
 [Per Occurrence Deductible of \$[100-2,000] per Inpatient Stay][[\$[100-1,000] per day] and Annual Deductible have been met]
 [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-10,000] Copayment per Inpatient Stay]

[Network:][U.S.:[[50-100]% [after Deductible has been met]][Deductible does not apply]]
 [100% after you pay a \$[100-1,000] Copayment per day]
 [100% after you pay a \$[100-2,000] Copayment per Inpatient Stay]
 [Per Occurrence Deductible of \$[100-2,000] per Inpatient Stay][[\$[100-1,000] per day] and Annual Deductible have been met]
 [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-10,000] Copayment per Inpatient Stay]
 [For [Network][U.S.] Benefits; Pre-service Notification is required if results in an Inpatient Stay.]

[Pre-service Notification is required if results in an Inpatient Stay.]

ADDITIONAL CORE BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
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[Acupuncture Services]

Benefits are limited as follows:
 [[10-100] visits per year]
 [[10-100] visits per year, not to exceed \$[100-5,000] in Eligible Expenses per year]
 [\$[100-5,000] in Eligible Expenses per year]]
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[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]]
 [100% after you pay a \$[5-75] Copayment per visit]
 [100% after you pay a \$[5-100] Copayment per visit for the first [#] visits]

[[50-100]% [after Deductible has been met]]
 [100% after you pay a \$[5-75] Copayment per visit]
 [100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any

in a year; [50-90]% for any subsequent visits in that year]

subsequent visits in that year] [Non-Network Benefits are not available]

[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]
[100% after you pay a \$[5-75] Copayment per visit]
[100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

Ambulance Services – Emergency and Non-Emergency

Ground Ambulance

[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[300-1,000] Copayment per day]
[100% after you pay a \$[25-300] Copayment per transport]
[100% after you pay a \$[300-1,000] Copayment per day, up to a per day maximum of \$[300-1,000]]

[[50-100]% [after Network Deductible has been met]][Deductible does not apply]]
[100% after you pay a \$[300-1,000] Copayment per day]
[100% after you pay a \$[25-300] Copayment per transport]

[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[300-1,000] Copayment per day]
[100% after you pay a \$[25-300] Copayment per transport]
[100% after you pay a \$[300-1,000] Copayment per day, up to a per day maximum of \$[300-1,000]]

Air Ambulance

[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]]
[100% after you pay a \$[2,500-10,000] Copayment per day]
[100% after you pay a \$[25-2,500] Copayment per transport]
[100% after you pay a \$[2,500-10,000] Copayment per day, up to a per day maximum of \$[2,500-10,000]]

[[50-100]% [after Network Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[2,500-10,000] Copayment per day] [100% after you pay a \$[25-2,500] Copayment per transport]

[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]
[100% after you pay a \$[2,500-10,000] Copayment per day]
[100% after you pay a \$[25-2,500] Copayment per transport]
[100% after you pay a \$[2,500-10,000] Copayment per day, up to a per day maximum of \$[2,500-10,000]]

[For [Network][U.S.] Benefits; Pre-service Notification is required for Non-Emergency Ambulance.]

[Pre-service Notification is required for Non-Emergency Ambulance.]

[Congenital Heart Disease (CHD) Surgeries]

[Benefits are limited to \$[30,000 - 250,000] per CHD surgery.]

[International:][[50-100]% [after Deductible has been met]][Deductible

[[50-100]% [after Deductible has been met]]

does not apply]]
 [100% after you pay a \$[100-1,000]
 Copayment per day]
 [100% after you pay a \$[100-2,000]
 Copayment per Inpatient Stay]
 [100% after you pay a \$[100-1,000]
 Copayment per day to a maximum \$[100-
 10,000] Copayment per Inpatient Stay]

[Network:][U.S.]:[[50-100]% [after
 Deductible has been met]][Deductible
 does not apply]]
 [100% after you pay a \$[100-1,000]
 Copayment per day]
 [100% after you pay a \$[100-2,000]
 Copayment per Inpatient Stay]
 [Per Occurrence Deductible of [\$[100-
 2,000] per Inpatient Stay][[\$100-1,000] per
 day] and Annual Deductible have been
 met]
 [100% after you pay a \$[100-1,000]
 Copayment per day to a maximum \$[100-
 5,000] Copayment per Inpatient Stay]

[For [Network][U.S.] Benefits; Pre-service
 Notification is required if results in an
 Inpatient Stay.]

[100% after you pay a \$[100-1,000]
 Copayment per day]
 [100% after you pay a \$[100-2,000]
 Copayment per Inpatient Stay]
 [Per Occurrence Deductible of [\$[100-
 2,000] per Inpatient Stay][[\$100-1,000]
 per day] and Annual Deductible have
 been met]
 [100% after you pay a \$[100-1,000]
 Copayment per day to a maximum \$[100-
 5,000] Copayment per Inpatient Stay]

[Benefits are limited to [\$30,000-
 \$250,000] per surgery]
 [Pre-service Notification is required.]

[Dental Services – Accident Only]

[Benefits are limited as follows:
 \$[2,000-5,000] maximum per
 year
 \$[500-1,500] maximum per
 tooth]

[International:][[50-100]% [after
 Deductible has been met]][Deductible
 does not apply]]
 [100% after you pay a \$[5-75] Copayment
 per visit]

[Network:][U.S.]:[[50-100]% [after
 Deductible has been met]][Deductible
 does not apply]]
 [100% after you pay a \$[5-75] Copayment
 per visit]

[For [Network][U.S.] Benefits; Pre-service
 Notification is required for Non-
 Emergency Ambulance.]

[[50-100]% [after Network Deductible
 has been met]][Deductible does not
 apply]][100% after you pay a \$[5-75]
 Copayment per visit]

[Pre-service Notification is required
 for Non-Emergency Ambulance.]

ADDITIONAL CORE BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. [International:]	
Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment.	[For diabetes equipment, Benefits will be the same as those stated under Durable Medical Equipment. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]	

[Network and Non-Network:][U.S.:] Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.

[For [Network][U.S.] Benefits; Pre-service Notification is required for Durable Medical Equipment [and Diabetes Equipment] in excess of \$[1,000-5,000].]

[Pre-service Notification is required for Durable Medical Equipment [and Diabetes Equipment] in excess of \$[1,000-5,000].]

[Durable Medical Equipment]

[Benefits are limited as follows:
 \$[500-100,000] per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every [year] [two-five] years.]
 [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 [not] included in the annual limits stated above.]

[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]]

[[50-100]% [after Deductible has been met]]

[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]

[For [Network][U.S.] Benefits; Pre-service Notification is required for Durable Medical Equipment in excess of \$[1,000-5,000].]

[Pre-service Notification is required for Durable Medical Equipment in excess of \$[1,000-5,000].]

This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.

[Hearing Aids]

[Benefits are limited as follows:
 [Limited to \$[2,800 – 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year][[three-five] years].] [No Copayment, Coinsurance or Deductible will be applicable to Network or non-Network Hearing Aid Coverage.]

[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]]

[[50-100]% [after Deductible has been met]]

[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]

[Home Health Care]

[Benefits are limited as follows:
 [[40-200] visits per year] \$[500-5,000 per year] [[40-200] visits per year to a maximum of \$[500-5,000] in Eligible Expenses per year.] [[40-200] visits per year for Network Benefits and [40-200] visits per year for Non-Network

[[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]]
 [100% after you pay a \$[5-50] Copayment per visit]

[[50-100]% [after Deductible has been met]]
 [100% after you pay a \$[5-50] Copayment per visit]

[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]

Benefits. One visit equals up to four hours of skilled care services.]]

[100% after you pay a \$[5-50] Copayment per visit]

[For [Network][U.S.] Benefits; Pre-service Notification is required.]

[Pre-service Notification is required.]

ADDITIONAL CORE BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
Hospice Care		
	<p>[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per day]</p> <p>[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-100] Copayment per day]</p> <p><i>[For [Network][U.S.] Benefits; Pre-service Notification is required.]</i></p>	<p>[[50-100]% [after Deductible has been met]] [100% after you pay a \$[5-100] Copayment per day]</p> <p><i>[Pre-service Notification is required.]</i></p>
[Infertility Services]		
<p>[Benefits are limited as follows: \$[2,000-30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the Outpatient Prescription Drug Rider.] [This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under Physician’s Office Services – Sickness and Injury.]</p>	<p>[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]]</p> <p>[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]</p> <p><i>[For [Network][U.S.] Benefits; Pre-service Notification is required.]</i></p>	<p>[[50-100]% [after Deductible has been met]] [Non-Network Benefits are not available.]</p> <p><i>[Pre-service Notification is required.]</i></p>
Lab, X-Ray and Diagnostics - Outpatient		
<p>For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.</p>	<p>[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5 -100] Copayment per service]</p> <p>[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]</p>	<p>[[50-100]% [after Deductible has been met]]</p>
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	<p>[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[25-500] Copayment per service]</p> <p>[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]</p>	<p>[[50-100]% [after Deductible has been met]] [100% after you pay a \$[25-500] Copayment per service]</p>

[100% after you pay a \$[25-500]
Copayment per service]

[Obesity Surgery]

[Benefits are limited as follows:
\$[50,000-250,000] per Covered Person
during the entire period of time a
Covered Person is enrolled for
coverage under the Policy.]

Depending upon where the Covered
Health Service is provided
Benefits will be the same as those stated
under each Covered Health Service
category in this Benefit Summary.

[Benefits are limited \$[25,000 –
30,000]

*[For [Network][U.S.] Benefits; Pre-service
Notification is required.]*

[Pre-service Notification is required.]

[Ostomy Supplies]

[Benefits are limited as follows:
\$[500-25,000] per year.]

[International:][[50-100]% [after
Deductible has been met][Deductible
does not apply]]

[[50-100]% [after Deductible has been
met]

[Network:][U.S.:][[50-100]% [after
Deductible has been
met][Deductible does not apply]]

Pharmaceutical Products - Outpatient

This includes medications administered
in an outpatient setting, in the
Physician's Office and by a Home
Health Agency.

[International:][[50-100]% [after
Deductible has been met][Deductible
does not apply]]

[[50-100]% [after Deductible has been
met]]

[Network:][U.S.:][[50-100]% [after
Deductible has been met][Deductible
does not apply]]

ADDITIONAL CORE BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
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Physician Fees for Surgical and Medical Services

[International:][[50-100]% [after
Deductible has been met][Deductible
does not apply]]

[[50-100]% [after Deductible has been
met]]

[Designated Network: [50-100]% [after
Deductible has been met][Deductible
does not apply]]

[Network:][U.S.:][[50-100]% [after
Deductible has been met][Deductible
does not apply]]

Pregnancy – [Maternity Services] [Complications of Pregnancy only]

Depending upon where the Covered Health Service is provided, Benefits will be
the same as those stated under each covered Health Service category in this
Benefit Summary.

[Network:][U.S.:]

[For services provided in the
Physician's Office, a Copayment will
only apply to the initial office visit.]

*[For [Network][U.S.] Benefits; [Pre-
service Notification is required if Inpatient
Stay exceeds 48 hours following a normal
vaginal delivery or 96 hours following a
cesarean section delivery.]*

*[Pre-service Notification is required if
Inpatient Stay exceeds 48 hours
following a normal vaginal delivery or
96 hours following a cesarean section
delivery.]*

Prosthetic Devices and Services

[Benefits are limited as follows for the
International Benefit:

[International:][[50-100]% [after
Deductible has been met][Deductible

[[50-100]% [after Deductible has been
met]]

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].]

does not apply]]

[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]]

[Benefits are limited as follows for the [Network and Non-Network] [U.S.] Benefit:

Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years.

This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.

Reconstructive Procedures

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.

[For [Network][U.S.] Benefits; Pre-service Notification is required.] [Pre-service Notification is required.]

ADDITIONAL CORE BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
Rehabilitation Services – Outpatient Therapy [and Manipulative Treatment]		
<p>[Benefits are limited as follows: [10-100] visits of physical therapy [10-100] visits of occupational therapy [[10-100] visits of Manipulative Treatment] [10 -100] visits of speech therapy [10-100] visits of pulmonary rehabilitation [10-100] visits of cardiac rehabilitation [10-100] visits of post-cochlear implant aural therapy] [[10-100] visits of vision therapy]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [and vision therapy] is limited to [10- 160] visits per year.] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [and vision therapy] is limited to \$[750- 12,000] per year.]</p>	<p>[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-75] Copayment 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] [Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]] [100% after you pay a \$[5-75] Copayment per visit] [100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]</p>	<p>[[50-100]% [after Deductible has been met]] [100% after you pay a \$[5-75] Copayment per visit] [100% after you pay a \$[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]</p>

[Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [and vision therapy] are limited to [10-160] visits per year. Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [and vision therapy] are limited to [10-160] visits per year.]

[For [Network][U.S.] Benefits; Pre-service Notification is required for certain services.]

[Pre-service Notification is required for certain services.]

Scopic Procedures – Outpatient Diagnostic and Therapeutic

<p>Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy</p> <p>For Preventive Scopic Procedures, refer to the Preventive Care Services category.</p>	<p>[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]</p> <p>[Network:][U.S.:][[50-100]% [after Deductible has been met]][Deductible does not apply]</p>	<p>[[50-100]% [after Deductible has been met]]</p>
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ADDITIONAL CORE BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
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Skilled Nursing Facility / Inpatient Rehabilitation Facility Services

<p>[Benefits are limited as follows: [[40-180] days per year] [[40-180] days per year for Network Benefits] [40-180] days per year for Non-Network Benefits]]</p>	<p>[International:][[50-100]% [after Deductible has been met]][Deductible does not apply]</p> <p>[100% after you pay a \$[50-1,000] Copayment per day] [100% after you pay a \$[50-2,000] Copayment per Inpatient Stay] [100% after you pay a Copayment of \$[50 – 1,000] per day to a maximum Copayment of \$[50 – 5000] per Inpatient Stay]</p> <p>[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 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.]</p> <p>[Network:][U.S.:] [[50-100]% [after Deductible has been</p>	<p>[[50-100]% [after Deductible has been met]]</p> <p>[100% after you pay a \$[50-1,000] Copayment per day] [100% after you pay a \$[50-2,000] Copayment per Inpatient Stay] [100% after you pay a \$[50-1,000] Copayment per day to a maximum \$[50-10,000] Copayment per Inpatient Stay]</p>
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met][Deductible does not apply]
 [100% after you pay a \$[50-1,000]
 Copayment per day]
 [100% after you pay a \$[50-2,000]
 Copayment per Inpatient Stay]
 [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 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.]
 [100% after you pay a \$[50-1,000]
 Copayment per day to a maximum \$[50-
 5,000] Copayment per Inpatient Stay]
[For [Network][U.S.] Benefits; Pre-service Notification is required.] *[Pre-service Notification is required.]*

Surgery - Outpatient

[International:][[50-100]% [after
 Deductible has been met]][Deductible
 does not apply]] *[[50-100]% [after Deductible has been
 met]]*
 [[100% after you pay a \$[10 - 1,000]
 Copayment per date of service] *[[100% after you pay a \$[10 - 1,000]
 Copayment per date of service]*
 [100% after you pay a Copayment of \$[10
 – 1,000] per date of service, to a
 maximum Copayment of \$[10 – 5,000] per
 year]] *[Per Occurrence Deductible of \$[10-
 1,000] per date of service and Annual
 Deductible have been met]*

[Network:][U.S.:][[50-100]% [after
 Deductible has been met]][Deductible
 does not apply]]
 [[100% after you pay a \$[10 - 1,000]
 Copayment per date of service]
 [Per Occurrence Deductible of \$[10-
 1,000] per date of service and Annual
 Deductible have been met]

Temporomandibular Joint Services

[Benefits are limited as follows for the
 [Network and Non-Network] [U.S.]
 Benefit:
 \$[1,000 - 20,000] per year.]

International:
 Benefit category does not apply to International Benefits

[Network and Non-Network:][U.S.:]
 Depending upon where the Covered Health Service is provided, Benefits will be
 the same as those stated under each Covered Health Service category in this
 Benefit Summary.
[For [Network][U.S.] Benefits; Pre-service Notification is required.] *[Pre-service Notification is required.]*

Therapeutic Treatments - Outpatient

Therapeutic treatments include, but are
 not limited to:
 Dialysis
 Intravenous chemotherapy or other
 intravenous infusion therapy
 Radiation oncology

[International:][[50-100]% [after
 Deductible has been met]][Deductible
 does not apply]] *[[50-100]% [after Deductible has been
 met]]*
 [100% after you pay a Copayment of \$[25
 – 100] per treatment]]
 [Network:][U.S.:][[50-100]% [after
 Deductible has been met]][Deductible
 does not apply]]

[For [Network][U.S.] Benefits; Pre-service Notification is required for certain services.]

[Pre-service Notification is required for certain services.]

ADDITIONAL CORE BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
Transplantation Services	<p>[International:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[100 - 1,000] Copayment per day] [100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-5,000] Copayment per Inpatient Stay]</p> <p>[Network:][U.S.:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[100 - 1,000] Copayment per day] [100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay] [Per Occurrence Deductible of [\$[100-2,000] per Inpatient Stay][\\$100-1,000] per day] and Annual Deductible have been met] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-5,000] Copayment per Inpatient Stay] [For Network Benefits, services must be received at a Designated Facility.]</p> <p><i>[For [Network][U.S.] Benefits; Pre-service Notification is required.]</i></p>	<p>[[50-100]% [after Deductible has been met]] [100% after you pay a \$[100 - 1,000] Copayment per day] [100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay] [Non-Network Benefits are not available.] [Per Occurrence Deductible of [\$[100-2,000] per Inpatient Stay][\\$100-1,000] per day] and Annual Deductible have been met] [100% after you pay a \$[100-1,000] Copayment per day to a maximum \$[100-5,000] Copayment per Inpatient Stay]</p> <p>[Benefits are limited to \$[30,000-250,000] per Transplant.] <i>[Pre-service Notification is required.]</i></p>
[Vision Examinations] [Benefits are limited as follows: [1 exam] [[2-3] exams] [every [2-3] years] [per year]]	<p>[International:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a [\$5 - 75] Copayment per visit]</p> <p>[Network:][U.S.:][[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a [\$5 - 75] Copayment per visit]</p>	<p>[Non-Network Benefits are not available] [100% after you pay a [\$5 - 75] Copayment per visit] [[50-100]% [after Deductible has been met]]</p>
[Wigs] [Benefits are limited as follows: [\$[100 - 1,000] per year.] [\$[100 - 5,000] every [24 - 36] months.]]	<p>[International:][[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p>[Network:][U.S.:][[50-100]% [after Deductible has been met][Deductible does not apply]]</p>	<p>[[50-100]% [after Deductible has been met]]</p>

STATE MANDATED BENEFITS

Types of Coverage	[[International and [U.S.] [Network] Benefits]	[Non-Network Benefits]
[Clinical Trials]		
[Participation in a qualifying clinical trial for the treatment of: Cancer Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees]	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.] International: To be a qualifying clinical trial for services outside the United States, a clinical trial must meet all of the criteria as described under Clinical Trials in the Global Solutions Rider. <i>[For [Network][U.S.] Benefits; Pre-service Notification is required.]</i>	<i>[Pre-service Notification is required.]</i>
Dental Services - Anesthesia and Hospitalization		
	International: Benefit category does not apply to International Benefits. Benefits are limited as follows for the [Network and Non-Network] [U.S.] Benefit: Benefits will be the same as those stated under Hospital - Inpatient Stay in this Benefits Summary. <i>[For [Network][U.S.] Benefits; Pre-service Notification is required.]</i>	<i>[Pre-service Notification is required.]</i>
In Vitro Fertilization Services		
Benefits are limited as follows for the [Network and Non-Network] [U.S.] Benefit: \$15,000 lifetime maximum.	International: Benefit category does not apply to International Benefits [Network;][U.S.:] [[50 - 100]% [after Deductible has been met][Deductible does not apply]] <i>[For [Network][U.S.] Benefits; Pre-service Notification is required.]</i>	[[50 - 100]%] [Non-Network Benefits are not available.] <i>[Pre-service Notification is required.]</i>
Medical Foods		
	International: Benefit category does not apply to International Benefits [Network;][U.S.:] Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100] % [or as provided under the Outpatient Prescription Drug Rider].	Same as Network
Mental Health Services		
	[International:] [Inpatient] [[50-100]% [after Deductible has been met]] [100% after you pay a \$[100 - 1,000] Copayment per day] [100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a \$[100 - 1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay]	[Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a \$[100 - 1,000] Copayment per day] [100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a \$[100 - 1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay] [Outpatient]

[Outpatient]

[[50-100]% [after Deductible has been met][Deductible does not apply]]
[100% after you pay a \$[5 - 100] Copayment per visit]
[100% after you pay a \$[5 - 75] Copayment per individual visit; \$[5 - 75] Copayment per group visit]
[100% for visits for medication management]

[[50-100]% [after Deductible has been met][Deductible does not apply]]
[100% after you pay a \$[5 - 100] Copayment per visit]
[100% after you pay a \$[5 - 75] Copayment per individual visit; \$[5 - 75] Copayment per group visit]
[100% for visits for medication management]

[Network:][U.S.:]

[Inpatient]

[[50-100]% [after Deductible has been met][Deductible does not apply]]
[100% after you pay a \$[100 - 1,000] Copayment per day]
[100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay]
[100% after you pay a \$[100 - 1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay]

[Outpatient]

[[50-100]% [after Deductible has been met][Deductible does not apply]]
[100% after you pay a \$[5 - 100] Copayment per visit]
[100% after you pay a \$[5 - 75] Copayment per individual visit; \$[5 - 75] Copayment per group visit]
[100% for visits for medication management]

[For [Network][U.S.] Benefits; Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]

[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]

[Musculoskeletal Disorders of the Face, Neck or Head]

International:
Benefit category does not apply to International Benefits

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 *Schedule of Benefits*.

[Network:][U.S.:]
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 *Schedule of Benefits*.

[For [Network][U.S.] Benefits; Pre-service Notification is required.]

[Pre-service Notification is required.]

[Neurobiological Disorders – Autism Spectrum Disorder Services]

[International:]

[Inpatient]

[Inpatient]

[[50-100]% [after Deductible has been met][Deductible does not apply]]

[[50-100]% [after Deductible has been met][Deductible does not apply]]

met]]
[100% after you pay a \$[100 - 1,000]
Copayment per day]
[100% after you pay a \$[100 - 2,000]
Copayment per Inpatient Stay]
[100% after you pay a \$[100 - 1,000]
Copayment per day to a maximum \$[100 -
5,000] Copayment per Inpatient Stay]

[100% after you pay a \$[100 - 1,000]
Copayment per day]
[100% after you pay a \$[100 - 2,000]
Copayment per Inpatient Stay]
[100% after you pay a \$[100 - 1,000]
Copayment per day to a maximum
\$[100 - 5,000] Copayment per
Inpatient Stay]

[Outpatient]

[Outpatient]

[[50-100]% [after Deductible has been
met][Deductible does not apply]]
[100% after you pay a \$[5 -100]
Copayment per visit]
[100% after you pay a \$[5 - 75]
Copayment per individual visit; \$[5 - 75]
Copayment per group visit]
[100% for visits for medication
management]

[[50-100]% [after Deductible has been
met][Deductible does not apply]]
[100% after you pay a \$[5 - 100]
Copayment per visit]
[100% after you pay a \$[5 - 75]
Copayment per individual visit; \$[5 -
75] Copayment per group visit]
[100% for visits for medication
management]

[Network:][U.S.:]
[Inpatient]

[[50-100]% [after Deductible has been
met][Deductible does not apply]]
[100% after you pay a \$[100 - 1,000]
Copayment per day]
[100% after you pay a \$[100 - 2,000]
Copayment per Inpatient Stay]
[100% after you pay a \$[100 - 1,000]
Copayment per day to a maximum \$[100 -
5,000] Copayment per Inpatient Stay]

[Outpatient]

[[50-100]% [after Deductible has been
met][Deductible does not apply]]
[100% after you pay a \$[5 - 100]
Copayment per visit]
[100% after you pay a \$[5 - 75]
Copayment per individual visit; \$[5 - 75]
Copayment per group visit]
[100% for visits for medication
management]

*[For [Network][U.S.] Benefits; Pre-service
Notification is required from the Mental
Health/Substance Use Disorder
Designee.]*

*[Pre-service Notification is required
from the Mental Health/Substance Use
Disorder Designee.]*

Orthotic Devices and Services

Benefits are limited as follows for the
[Network and Non-Network] [U.S.]
Benefit:

International:
Benefit category does not apply to
International Benefits

[[50-100]% [after Deductible has been
met][Deductible does not apply]]

Benefits for replacement are limited to a
single purchase of each type of orthotic
device every three years.

[Network;][U.S.:]
[[50-100]% [after Deductible has been
met][Deductible does not apply]]

Substance Use Disorder Services

<p>[International:]</p> <p>[Inpatient]</p> <p>[[50-100]% [after Deductible has been met]]</p> <p>[100% after you pay a \$[100 - 1,000] Copayment per day]</p> <p>[100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay]</p> <p>[100% after you pay a \$[100 - 1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p>[100% after you pay a \$[5 - 100] Copayment per visit]</p> <p>[100% after you pay a \$[5 - 75] Copayment per individual visit; \$[5 - 75] Copayment per group visit]</p> <p>[100% for visits for medication management]</p> <p>[Network:][U.S.:]</p> <p>[Inpatient]</p> <p>[[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p>[100% after you pay a \$[100 - 1,000] Copayment per day]</p> <p>[100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay]</p> <p>[100% after you pay a \$[100 - 1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p>[100% after you pay a \$[5 - 100] Copayment per visit]</p> <p>[100% after you pay a \$[5 - 75] Copayment per individual visit; \$[5 - 75] Copayment per group visit]</p> <p>[100% for visits for medication management]</p> <p>[For [Network][U.S.] Benefits; Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.] [Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]</p>	<p>[Inpatient]</p> <p>[[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p>[100% after you pay a \$[100 - 1,000] Copayment per day]</p> <p>[100% after you pay a \$[100 - 2,000] Copayment per Inpatient Stay]</p> <p>[100% after you pay a \$[100 - 1,000] Copayment per day to a maximum \$[100 - 5,000] Copayment per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[50-100]% [after Deductible has been met][Deductible does not apply]]</p> <p>[100% after you pay a \$[5 - 100] Copayment per visit]</p> <p>[100% after you pay a \$[5 - 75] Copayment per individual visit; \$[5 - 75] Copayment per group visit]</p> <p>[100% for visits for medication management]</p>
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INTERNATIONAL BENEFITS

Types of Coverage	[International Benefits]
[Culturally-Based Services]	

[International:][50-100]% [after Deductible

has been met][Deductible does not apply]]

[Emergency Evacuation]

[International:][50-100]% [after Deductible has been met][Deductible does not apply]]
[100% after you pay a Copayment of \$[25-300] per transport]
[100% after you pay 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]]

[Medical Repatriation]

[International:][50-100]% [after Deductible has been met][Deductible does not apply]]
[100% after you pay a Copayment of \$[25-300] per transport]
[100% after you pay 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]]

[Outpatient Prescription Drugs]

[International:][50-100]% [after Deductible has been met][Deductible does not apply]]
[100% after you pay a Copayment of \$[1-200] per prescription order or refill]]

[Repatriation of Remains]

[International:][50-100]% [after Deductible has been met][Deductible does not apply]]
[100% after you pay a Copayment of \$[25-300] per transport]
[100% after you pay 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]]

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

MEDICAL EXCLUSIONS

It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

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

Dental

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

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities Orthotic appliances that straighten or re-shape a body part. This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1 of the COC. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. [Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.] [Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in Section 1 of the COC.]

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. [(This exclusion does not apply to International Benefits.)] 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. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental, Investigational or Unproven Services

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

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include:

cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet or subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

MEDICAL EXCLUSIONS CONTINUED

Medical Supplies [and Equipment]

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

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

Tubing and masks, [except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in Section 1 of the COC.] [Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.]

Mental Health

[Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.] [Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.] [Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders-Autism Spectrum Disorder Services in Section 1 of the COC.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[Services for the treatment of mental illness or mental health conditions [that the Enrolling Group has elected to provide through a separate benefit plan].]

MEDICAL EXCLUSIONS CONTINUED

Neurobiological Disorders – Autism Spectrum Disorders

[Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Unproven Services.] [Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.] [Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

[Services for the treatment of autism spectrum disorders as the primary diagnosis [that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes Autistic Disorder, Rhetts's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).)]

Nutrition

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

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

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to medical foods for which Benefits are provided as described in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment;-treadmills; vehicle modifications such as van lifts; video players, whirlpools.

MEDICAL EXCLUSIONS CONTINUED

Physical Appearance

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

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. [Rehabilitative services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders][Autism Spectrum Disorders].] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy and vision therapy.] Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery[,] [and] jaw alignment, except as a treatment of obstructive sleep apnea. [This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in Section 1 of the COC.] [[Surgical and non-surgical treatment of obesity] [Non-surgical treatment of obesity] [Surgical treatment of obesity.] [Stand-alone multi-disciplinary smoking cessation programs.] [Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC.]

Providers

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

MEDICAL EXCLUSIONS CONTINUED

Reproduction

[Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment, except for In Vitro Fertilization Services for which Benefits are provided as described in Section 1 of the COC. This exclusion does not apply to services required to treat or correct underlying causes of infertility.] [The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services.] Surrogate parenting, donor eggs, donor sperm and host uterus, [Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.] The reversal of voluntary sterilization [and voluntary sterilization]. [Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).] [Contraceptive supplies and services.] [Fetal reduction surgery.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).] [Maternity related medical services for Enrolled Dependent children.]

Services Provided under Another Plan

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

Substance Use Disorders

[Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadon), Cyclazocine, or their equivalents.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

[Services for the treatment of substance use disorder services [that the Enrolling Group has elected to provide through a separate benefit plan].

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs. [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

MEDICAL EXCLUSIONS CONTINUED

Travel

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

Types of Care

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

Vision and Hearing

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

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, [travel], [career or employment,] insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services when claims payment and/or coverage is prohibited by applicable law.

MEDICAL EXCLUSIONS CONTINUED

UnitedHealthcare Insurance Company

SERFF Tracking Number: INCS-127207782 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 49133
 Company Tracking Number: BENSUM.GSCPON.I.09
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: UHIC 2011 Benefit Summary
 Project Name/Number: UHIC 2011 Benefit Summary/UHIC 2011 Benefit Summary

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/30/2011
Comments: Readability - NA this is a benefit summary Consumer Notice - provided under separate document		
Attachment: ARKANSAS CERTIFICATE OF COMPLIANCE.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	06/30/2011
Comments: 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.		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	06/30/2011
Bypass Reason: NA		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Authorization Letter	Approved-Closed	06/30/2011
Comments:		
Attachment: 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.



(Signature)

Assistant Secretary

(Title)

6/20/2011

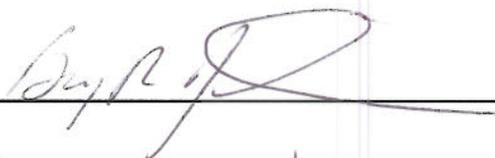
(Date)

Benefit Summary Form Number: BENSUM.GSCPON.I.09.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