



All benefits are subject to Usual, Customary and Reasonable (UCR) fees. The benefits, coverage and exclusions listed herein are only a summary, and are subject to the specific terms and conditions of the plan concerning eligible benefit, limitations, eligibility and exclusions. Please refer to the Policy Wording for details.

Penalties to the benefits payable under this plan may apply if the requirements are not met. Please refer to the section labeled Pre-Certification Requirements and Procedures in the plan's Policy Wording. You must contact the pre-certification provider number listed on your identification card.

The following services require Pre-Certification:

Hospitalization | Surgeries | Diagnostic Testing | Oncology Treatment | Repatriation of Mortal Remains | Therapy | Organ Transplant | Medical Air Evacuation / Air Ambulance | Rehabilitation | Home Health Care | Extended Care Facility

Failure to perform the pre-certification requirements within a minimum of 5 business days prior to the planned treatment of a non-emergency service or within 72 hours of an emergency service, will result in a **penalty of 30%** of the allowable charge for the entire episode of care. The penalty will not count toward the deductible or co-insurance maximum as defined on the Certificate of Coverage.

General	Coverage					
Area of Coverage	Worldwide including U.S. Coverage					
Policy Lifetime Maximum per Insured	\$1,000,000					
Policy Year Deductible Options (Certificate of Coverage defines your selection) <ul style="list-style-type: none"> • Individual • Family <i>Deductible for Family is a maximum of two (2) individually met deductibles per policy year.</i>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td style="text-align: center;">\$250</td></tr> <tr><td style="text-align: center;">\$500</td></tr> <tr><td style="text-align: center;">\$1,000</td></tr> <tr><td style="text-align: center;">\$2,500</td></tr> <tr><td style="text-align: center;">\$5,000</td></tr> </table>	\$250	\$500	\$1,000	\$2,500	\$5,000
\$250						
\$500						
\$1,000						
\$2,500						
\$5,000						
Co-Insurance Limit [Out-of-Pocket] Outside the U.S.	No co-insurance applies					
Co-Insurance Limit [Out-of-Pocket] U.S. In-Network	After the deductible, 20% of the first \$5,000 of covered medical charges					
Co-Insurance Limit [Out-of-Pocket] U.S. Out-of-Network	After the deductible, 50% of covered medical charges					
Policy Waiting Period	30 days					

Inpatient Benefits	U.S. In Network	U.S. Out of Network	Outside the U.S.
Hospital Room and Board 60 days per hospital admission. 240 days per policy year.	80% Up to \$600 per day	50% Up to \$600 per day	100% Up to \$600 per day
Intensive Care Unit (ICU) 45 days per confinement. 180 days per policy year.	80% Up to \$1,500 per day	50% Up to \$1,500 per day	100% Up to \$1,500 per day
Inpatient Ancillary Hospital Services Including, but not limited to X-rays, drugs, bandages, operating room fees, surgical implants	80%	50%	100%
Inpatient Physician / Specialist Visits Limited to one visit per day per specialty	80%	50%	100%
Inpatient Surgery	80%	50%	100%
Surgeon's Fees	80%	50%	100%
Assistant's Surgeon's Fees	← 20% of the Primary Surgeon approved fees →		
Anesthesiologist's Fees	← 30% of the Primary Surgeon approved fees →		
Pre-Admission Testing Must be performed before non-emergency hospitalization	80%	50%	100%
Extended Care Facility 30 days per policy year	80%	50%	100%
Human Organ Transplant & Acquisition Subject to 12-month waiting period	80% \$250,000 lifetime maximum	Not covered	100% \$250,000 lifetime maximum
Inpatient Mental / Nervous Health	← Not covered →		
Outpatient Benefits	U.S. In Network	U.S. Out of Network	Outside the U.S.
Outpatient Surgery	80%	50%	100%
Surgeon's Fees	80%	50%	100%
Assistant's Surgeon's Fees	← 20% of the Primary Surgeon approved fees →		
Anesthesiologist's Fees	← 30% of the Primary Surgeon approved fees →		
Chiropractic Services	80% Up to \$50 per visit*	50% Up to \$50 per visit*	100% Up to \$50 per visit*
Diagnostic Testing MRI, CT Scan, PET Scan, and other diagnostic machine tests; Limited to \$250 per scan	80%	50%	100%

Dialysis	80%	50%	100%
Emergency Room Services If not admitted to the hospital, a co-payment of \$250 per visit will apply	80%	50%	100%
Home Health Care 30 days per policy year	80%	50%	100%
Hospice Care 30 days per policy year	80%	50%	100%
Outpatient Physician / Specialist Visits Limited to one visit per day	80% Up to \$70 per visit *	50% Up to \$70 per visit *	100% Up to \$70 per visit *
Oncology / Cancer Treatment	80%	50%	100%
Reconstructive Surgery Due to covered injury or illness	80%	50%	100%
Outpatient Rehabilitation / Therapeutic Services Physical, Speech, Occupational Therapy	← 30 visits per policy year →		
Outpatient Mental / Nervous Health Subject to 12-month waiting period	80% Up to \$60 per visit *	50% Up to \$60 per visit *	100% Up to \$60 per visit *
Wellness Benefit for Children under the age of 19 Subject to 12-month waiting period	100% Up to \$200 per policy year Deductible waived	50% Up to \$200 per policy year Deductible waived	100% Up to \$200 per policy year Deductible waived
Wellness Benefit for Adults Subject to 12-month waiting period	← Not covered →		
Alternative Medicine	U.S. In Network	U.S. Out of Network	Outside the U.S.
Aroma & Herbal Therapy	← Not covered →		
Magnetic Therapy	← Not covered →		
Vitamin Therapy	← Not covered →		
Acupuncture & Massage Therapy	← Not covered →		
Maternity Care (Optional Rider)	U.S. In Network	U.S. Out of Network	Outside the U.S.
Lifetime maximum of \$50,000; Subject to 10-month waiting period; Deductible waived for deductible options of \$2,500 or less 100% coverage up to the limits below for the insured female policyholder or insured dependent spouse only.			
Normal Delivery Prenatal and postnatal care	80% Up to \$5,000 per pregnancy	50% Up to \$5,000 per pregnancy	100% Up to \$5,000 per pregnancy

Cesarean Section	80% Up to \$7,500 per pregnancy	50% Up to \$7,500 per pregnancy	100% Up to \$7,500 per pregnancy
Complications of Pregnancy and Birth	80% \$50,000 lifetime maximum	50% \$50,000 lifetime maximum	100% \$50,000 lifetime maximum
Additional Benefits	U.S. In Network	U.S. Out of Network	Outside the U.S.
Congenital Disorders, Birth Defects & Hereditary Conditions	80% \$250,000 lifetime maximum	50% \$250,000 lifetime maximum	100% \$250,000 lifetime maximum
Durable Medical Equipment	80%	50%	100%
Prosthetic Limbs	80% Up to \$10,000 per prosthesis \$20,000 lifetime maximum	50% Up to \$10,000 per prosthesis \$20,000 lifetime maximum	100% Up to \$10,000 per prosthesis \$20,000 lifetime maximum
Prescription Medication	80% Up to \$20,000 per policy year	50% Up to \$20,000 per policy year	100% Up to \$20,000 per policy year
Emergency Dental Treatment To restore natural teeth damaged in a covered accident	80% Up to \$1,000 per policy year	50% Up to \$1,000 per policy year	100% Up to \$1,000 per policy year
Emergency Dental Treatment Due to sudden unexpected pain	←———— Not covered —————→		
Non-Professional Sports	←———— \$50,000 lifetime maximum —————→		
Emergency Medical Evacuation / Air Ambulance	←———— 100% up to \$50,000 policy year Deductible waived —————→		
Emergency Ground Ambulance	80% Up to \$1,500 per event	50% Up to \$1,500 per event	100% Up to \$1,500 per event
Emergency Transportation of 1 Family Member	←———— Not covered —————→		
Repatriation of Mortal Remains or Local Burial (In lieu of repatriation)	←———— \$25,000 lifetime maximum Deductible waived —————→		
Eye Examination One routine eye examination every two years	←———— Not covered —————→		
Eyeglasses or Contact Lenses Once every two years	←———— Not covered —————→		
Dental Care Subject to 6-month waiting period	←———— Not covered —————→		

All amounts are in USD.

*For Care plan option: Office visits, mental nervous and chiropractic visits combined have a maximum of 25 visits.