Schedule of Benefits

Association of Universities for Research in Astronomy (AURA)

Effective: January 1, 2022

MetLife

Navigating Life Together

Medical Schedule of Benefits

Eligible Classes

Employees	All active, Full-Time Employees of the Participating Employer who normally work at least twenty hours per week; 1. who are U.S.-based Employees on temporary assignment outside the U.S.; OR 2. who are non-U.S. based Employees working temporarily in an assignment country, who are neither a national of the assignment country nor the U.S. All eligible retirees who meet the following criteria: 1. who retire outside the US in Your assignment country or country of primary residence; and 2. who are at least 58 years of age, and who's age plus years of service with the Participating Employer equal at least 78 as of the date of retirement; and 3. have been covered as an active employee under Our plan for a two-year consecutive period prior to retirement; or as defined by the Participating Employer and agreed to by Us.
Dependents	Spouse, Same or Opposite Sex Domestic Partner, Child(ren) under age 26
Employee Contribution	Contributory

Plan Design (U.S. Care Included)

	International	In-Network U.S.	Out-of-Network U.S.
Deductibles Individual / Family	$100 / $200	$100 / $200	$100 / $200
Deductibles do accumulate across International, In-Network U.S. and Out-of-Network U.S. benefits.			
Covered Percentage	90%	90%	90%
Out-of-Pocket Maximum Individual / Family	$500 / $1,000	$500 / $1,000	$500 / $1,000
Out-of-Pocket (OOP) Maximums do accumulate across International, In-Network U.S. and Out-of-Network U.S. benefits. The OOP excludes payments made for Deductibles and benefit penalties incurred for failure to obtain Pre-Certification.			
Lifetime Maximum	Unlimited		
Benefit/Accumulation Period	Calendar Year		

Emergency and Urgent Care Services*

	International	In-Network U.S.	Out-of-Network U.S.
Emergency Room	90% After Deductible	90% After Deductible	90% After In-Network Deductible
Non-Emergency Use of the Emergency Room	90% After Deductible	90% After Deductible	90% After In-Network Deductible
Physician Office Visit	90% After Deductible	90% After Deductible	90% After Deductible
Specialist Office Visit	90% After Deductible	90% After Deductible	90% After Deductible
Radiological/Laboratory (in conjunction with ER visit)	90% After Deductible	90% After Deductible	90% After Deductible
Ambulance	90% After Deductible	100% (Deductible waived)	100% (Deductible waived)
Urgent Care	90% After Deductible	90% After Deductible	90% After Deductible

*However, Deductibles will be waived for expenses incurred in connection with an Accidental Injury that results in an Emergency Medical Condition.

Office Visits

	International	In-Network U.S.	Out-of-Network U.S.
Physician Office Visit (in person or through Telemedicine)	90% After Deductible	90% After Deductible	90% After Deductible
Specialist Office Visit	90% After Deductible	90% After Deductible	90% After Deductible

Mental Illness/Substance Abuse

	International	In-Network U.S.	Out-of-Network U.S.
Specialist Office Visit	90% After Deductible	90% After Deductible	90% After Deductible
Inpatient	90% After Deductible	90% After Deductible	90% After Deductible
Outpatient	90% After Deductible	90% After Deductible	90% After Deductible

Laboratory and Radiological Services (including, but not limited to, MRI's, MRS's, CAT Scans, PET Scans)

	International	In-Network U.S.	Out-of-Network U.S.
Independent Lab / X-Ray Facility	90% After Deductible	90% After Deductible	90% After Deductible

Hospital Services

	International	In-Network U.S.	Out-of-Network U.S.
In-patient Hospital Facility	90% After Deductible	90% After Deductible	90% After Deductible
Semi Private Room and Board **Private Room** **Special Care Units: ICU/CCU**	Avg. semi-private room rate Limited to the semi-private room rate (private room covered outside the U.S. only if no semi-private room equivalent is available) 2X Avg. semi-private room rate		
In-patient Hospital Physician Office Visit	90% After Deductible	90% After Deductible	90% After Deductible
In-patient Hospital Specialist Office Visit	90% After Deductible	90% After Deductible	90% After Deductible
Inpatient Services – other Healthcare Facilities including: • Rehabilitation Hospital • Skilled Nursing Facility • Sub-Acute Care Facility	90% After Deductible	90% After Deductible	90% After Deductible
Out-patient Hospital Facility	90% After Deductible	90% After Deductible	90% After Deductible
Out-patient Hospital Physician Office Visit	90% After Deductible	90% After Deductible	90% After Deductible
Out-patient Hospital Specialist Office Visit	90% After Deductible	90% After Deductible	90% After Deductible

Maternity

	International	In-Network U.S.	Out-of-Network U.S.
Initial Visit to Confirm Pregnancy	90% After Deductible	90% After Deductible	90% After Deductible
Specialist Office Visits	100% Deductible Waived	100% (Deductible Waived)	100% (Deductible Waived)
Laboratory and Radiological Services	90% After Deductible	90% After Deductible	90% After Deductible
Physician Delivery Charge	90% After Deductible	90% After Deductible	90% After Deductible
Delivery (Inpatient Hospital/Birthing Center)	90% After Deductible	90% After Deductible	90% After Deductible

Obesity/Bariatric Surgery (Must be Medically Necessary)

	International	In-Network U.S.	Out-of-Network U.S.
Specialist Office Visit	90% After Deductible	90% After Deductible	90% After Deductible
Inpatient Facility	90% After Deductible	90% After Deductible	90% After Deductible
Outpatient Facility	90% After Deductible	90% After Deductible	90% After Deductible
Physician Services	90% After Deductible	90% After Deductible	90% After Deductible

Prescription Drugs

	International	In-Network U.S.	Out-of-Network U.S.
Retail Drug	90% After Deductible	90% (Deductible Waived)	90% After Deductible
Mail Order Drug	Not Available	90% (Deductible Waived)	Not Available

Wellness

	International	In-Network U.S.	Out-of-Network U.S.
Well Baby/Child Care	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
	(for dependents under 18 covered for routine preventive care and immunizations)		
Adult Preventive Care (for persons 18 and older-one visit every 12 months)	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
Immunizations (Including Travel)	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
Mammograms	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
	• Age 35 through 39: one baseline exam • Age 40 through 49: one baseline exam every one or two years, based upon recommendation of a Physician • Age 50 or older: one per year • Based on Physician's evaluation that physical conditions, symptoms or risk factors indicate a probability of breast cancer higher than the general population: one exam		
Women's Preventive Care (for eligible females)	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
	• Annual well-woman visits • Prenatal visits • Screening for gestational diabetes for women who are 24 to 28 weeks pregnant and at the first prenatal visit for those who are at high risk of development of gestational diabetes • Screening and counseling for interpersonal and domestic violence annually • FDA-approved contraception methods & contraceptive counseling as prescribed; including birth control & sterilization (excludes reversals) • Breast-feeding support, supplies and counseling • HPV DNA testing every three years for women 30 years & older • Sexually-transmitted infection counseling and HIV screening & counseling annually		
Prostate Cancer Screenings (for eligible men age 50 and older up to once per year)	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
Gynecological Cancer Screenings (for eligible females up to once per year)	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
Colorectal Cancer Screenings	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
	(for persons age 50 or older, screening with annual fecal occult blood tests (3 specimens), flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double contrast barium enema every 5 years, or any combination of the most reliable screening tests available)		
Lead Screenings	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)

Other Covered Benefits

	International	In-Network U.S.	Out-of-Network U.S.
Temporomandibular joint dysfunction (TMJ) (up to $1,000 per lifetime)			
Specialist Office Visit	90% After Deductible	90% After Deductible	90% After Deductible
Outpatient	90% After Deductible	90% After Deductible	90% After Deductible
Infertility (Diagnosis and Treatment)	90% After Deductible	90% After Deductible	90% After Deductible
Family Planning	90% After Deductible	90% After Deductible	90% After Deductible
	• Office visits and counseling • Lab and radiology tests • Surgical sterilization procedures: Vasectomy (excludes reversals)		
Nutritional Evaluation (up to 3 visits per Calendar Year)	90% After Deductible	90% After Deductible	90% After Deductible
Applied Behavior Analysis	90% After Deductible	90% After Deductible	90% After Deductible
	(for treatment of autism spectrum disorder)		
Outpatient Short-Term Rehabilitative Therapy (up to a combined 60 visits per Calendar Year) **Includes:** • Physical Therapy • Occupational Therapy • Speech Therapy (Physical Therapy visits for the treatment of back pain are excluded from the visit limit outlined above)	90% After Deductible	90% After Deductible	90% After Deductible
Chiropractic Services	90% After Deductible	90% After Deductible	90% After Deductible
Acupuncture / Acupressure (up to a combined 20 visits per Calendar Year)	90% After Deductible	90% After Deductible	90% After Deductible
Home Health Care (up to 120 visits per Calendar Year)	90% After Deductible	90% After Deductible	90% After Deductible
Skilled Nursing Facility (up to 120 days per Calendar Year)	90% After Deductible	90% After Deductible	90% After Deductible
Inpatient Physical Rehabilitation Facility (up to 120 days per Calendar Year)	90% After Deductible	90% After Deductible	90% After Deductible

Other Covered Benefits (continued)

	International	In-Network U.S.	Out-of-Network U.S.
Hospice Care, Including Bereavement			
Inpatient	90% After Deductible	90% After Deductible	90% After Deductible
Outpatient	90% After Deductible	90% After Deductible	90% After Deductible
Allergy Treatment / Testing	90% After Deductible	90% After Deductible	90% After Deductible
Alternative Therapies	90% After Deductible	Not Available	Not Available
Durable Medical Equipment	90% After Deductible	90% After Deductible	90% After Deductible
Diabetes Supplies	90% After Deductible	90% After Deductible	90% After Deductible
Scalp Hair Prosthesis (up to $500 per Calendar Year)	90% After Deductible	90% After Deductible	90% After Deductible
Hearing Exams (once every 24 months)	90% After Deductible	90% After Deductible	90% After Deductible
Hearing Aids	90% After Deductible	90% After Deductible	90% After Deductible
	(once per ear every 3 years up to $1,000 for dependent children up to age 24)		
Vision			
Exams	100% once every 12 months (Deductible waived)		
Lenses, Frames, Hardware	100% up to $250 once every 12 months (Deductible waived)		

Additional Service Riders

Preferred Telemedicine Services	24-hr, 7 days per week access to medical consultations with a network of licensed providers on any mobile device. Covered at 100% (Deductible waived) when accessed through this preferred network.
Second Medical Opinion	A Second Medical Opinion from specialists at top medical centers is provided for serious illnesses upon request. These medical experts review the patient's medical records and provide a customized report, reviewing the diagnosis and recommending a personalized treatment plan based on the latest medical research.
Global Emergency Assistance	24-hr, 7 days per week assistance services including telephonic translation, medical and legal referrals, evacuation/repatriation, dependent return, and concierge-level travel assistance. Covered at 100% (Deductible waived) up to $250,000 per occurrence for Medical Evacuation, $10,000 for Travel After Medical Evacuation, $25,000 for Repatriation of Remains, $10,000 for Emergency Family Travel and $10,000 for Return of Dependents
Employee Assistance Program	24-hour, 7 days a week unlimited telephonic support for members including consultation, counseling and provider referral. In-person counseling for members up to 6 visits per year. 24-hour, 7 days a week unlimited telephonic support for managers including problem employee and crisis consultation.

Dental Schedule of Benefits

Eligible Classes

Employees	All active, Full-Time Employees of the Participating Employer who normally work at least twenty hours per week; 1. who are U.S.-based Employees on temporary assignment outside the U.S.; OR 2. who are non-U.S. based Employees working temporarily in an assignment country, who are neither a national of the assignment country nor the U.S. All eligible retirees who meet the following criteria: 1. who retire outside the US in Your assignment country or country of primary residence; and 2. who are at least 58 years of age, and who's age plus years of service with the Participating Employer equal at least 78 as of the date of retirement; and 3. have been covered as an active employee under Our plan for a two-year consecutive period prior to retirement; or as defined by the Participating Employer and agreed to by Us.
Dependents	Spouse, Same or Opposite Sex Domestic Partner, Child(ren) under age 26
Employee Contribution	Contributory

	Worldwide
Deductibles Preventive/Diagnostic, Basic and Major: Individual / Family Orthodontia: Per Individual	Combined: $25 / $50 $25
Annual Maximum: • Preventive/Diagnostic • Basic • Major	Combined $2,000
Lifetime Maximum: • Orthodontia	$1,500
Preventive/Diagnostic* • Oral Examination: Once every six months • Dental Prophylaxis (Cleanings): Once every six months • Fluoride Treatment: Once every six months (Up to age of 16) • Complete Mouth Survey or Panoramic X-Ray: Once every three years • Bitewing X-rays: Once every six months • Application of Sealants: Once per tooth every three years (Up to age 15)	100% (Deductible waived)

Dental Benefits (continued)

Basic* • Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery	80% After Deductible
Major • Dentures, Crowns, Bridges	50% After Deductible
Orthodontics (for Child Only up to age 19)	50% After Orthodontia Deductible

**All frequencies outlined above are measured from last date of service*

Exclusions and Limitations

Medical Insurance: Exclusions

We will not pay Medical Insurance benefits for charges incurred for:

1. services or supplies to the extent that benefits are available for the services or supplies elsewhere under the Group Policy or under any other plan of group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group to which the Participating Employer contributes or makes payroll deductions whether or not You or Your Insured Dependents are covered for such benefits;
2. services or supplies for which benefits are not payable because of Deductible or Co-payment provisions under the Group Policy or under any other plan of group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group to which the Participating Employer contributes or makes payroll deductions;
3. cosmetic surgery, unless the cosmetic surgery is required as a result of a covered accident to You or Your Insured Dependents while covered under the Group Policy;
4. eyeglasses, hearing aids or examinations for a prescription or fitting of eyeglasses, hearing aids; including any surgical procedures which are done primarily to correct a refractive error, hearing loss, unless specifically provided for elsewhere in the Group Policy.
5. treatment of the teeth or gums unless such expenses are incurred for:
    a) dental work necessitated by Accidental Injury to natural teeth sustained while You or Your Insured Dependents are covered for Medical Insurance under the Group Policy. Eligible charges are limited to services provided within ninety days of the Accidental Injury; or
    b) Hospital Room and Board or Miscellaneous Services or Supplies;
6. benefits that are not payable according to the section of the Group Policy entitled GENERAL LIMITATIONS.

Emergency Medical Evacuation Exclusions And Limitations

In addition to the provisions of the Group Policy titled “MEDICAL INSURANCE: EXCLUSIONS” and “GENERAL LIMITATIONS”, the following will apply solely to the benefits afforded under the Emergency Medical Evacuation benefits:

We will not pay Emergency Medical Evacuation benefits for charges incurred for:

1. services rendered without Pre-Certification from Us.
2. claims arising from depression or anxiety, mental or nervous disorder, alcohol or drug abuse addiction or overdose.
3. claims arising from elective cosmetic or plastic surgery, except as a result of a covered accident.
4. claims arising from You or Your Insured Dependents traveling against the advice of a Physician.
5. claims caused by or resulting from:
    a) any business or financial contractual obligations of You or Your Immediate Family Member;
    b) Change of plans or disinclination of You or Your Immediate Family Member to travel.

Prescription Drug Exclusions

In addition to the provisions of the Group Policy titled “MEDICAL INSURANCE: EXCLUSIONS” and “GENERAL LIMITATIONS”, the following will apply solely to the benefits afforded for all Prescription Drug benefits:

We will not pay Prescription Drug benefits for charges incurred for:

1. drugs which do not meet the definition of Prescription Drugs.
2. medication which is to be taken by or administered to You or Your Insured Dependents, in whole or part, while You or Your Insured Dependents, are patients in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
3. therapeutic devices or appliances including, but not limited to, colostomy supplies and support garments, regardless of intended use. (This exclusion does not apply to insulin syringes with needles, blood testing strips - glucose, urine testing strips - glucose, ketone testing strips and tablets, lancets and lancet devices which are covered.)
4. injectable drugs (This exclusion does not apply to insulin or self-administered injectables which can be injected subcutaneously which are covered.).
5. progesterone suppositories.
6. appetite suppressants and other weight loss products.
7. general and injectable vitamins (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections which are covered.).
8. any prescription refilled in excess of the supply limits or in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
9. replacement drugs resulting from a lost, stolen, broken or destroyed Prescription Drug order or refill.
10. unit dose packaging of drugs.
11. drugs available over-the-counter that do not require a Prescription Drug order or refill by federal, state or applicable law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug.
12. drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the person.
13. immunization agents, biological sera, blood or blood plasma.
14. drugs related to the reversal any sex transformation.
15. drugs for tobacco dependency or smoking cessation.
16. drugs for, or in connection with cosmetic surgery unless the You or Your Insured Dependents are injured as a result of an accident that occurs while he or she is covered for Medical Insurance under the Group Policy, which results in damage to his or her person requiring the cosmetic surgery.

Vision Insurance Exclusions

In addition to the provisions of the Group Policy titled “MEDICAL INSURANCE: EXCLUSIONS” and “GENERAL LIMITATIONS”, the following will apply solely to the benefits afforded under the Vision Insurance benefits:

We will not pay Vision Insurance benefits for charges incurred for:

1. more than one examination in any 12 consecutive month period.
2. more than one pair of lenses in any 12 consecutive month period.
3. more than one set of frames in any 12 consecutive month period.
4. non-prescription eyeglasses or lenses.
5. sunglasses, unless prescribed to be worn at substantially all times.
6. any coatings added to eyeglasses or lenses.

Vision Insurance Exclusions (continued)

7. examinations required for employment.
8. glasses or lenses required for employment.
9. any item or service not listed in the SCHEDULE OF BENEFITS.
10. surgical treatment of the eyes.
11. services or supplies to the extent that benefits are payable for the services or supplies elsewhere under the Group Policy.

Dental Insurance: Exclusions

In addition to the provisions of the Group Policy titled "GENERAL LIMITATIONS", the following will apply solely to the benefits afforded under the Dental Insurance benefits:

We will not pay Dental Insurance benefits for charges incurred for:

1. services not performed by a Dentist except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist and which are for:
    a) scaling and polishing of teeth; or
    b) fluoride treatments.
2. services which are primarily cosmetic.
3. repair or replacement of an orthodontic appliance.
4. services or appliances which restore or alter occlusion or vertical dimension.
5. restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
6. restorations or appliances used for the purpose of periodontal splinting.
7. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
8. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
9. decoration or inscription of any tooth, device, appliance, crown or other dental work.
10. missed appointments.
11. prescription drugs.
12. the following when charged by the Dentist on a separate basis:
    a) local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
13. dental services arising out of Accidental Injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
14. intraoral-periapical x-rays and other x-rays not specified as Covered Dental Services.
15. sedative fillings.
16. veneers.
17. local chemotherapeutic agents.
18. adjustments, repairs or re-cementing of Dentures.
19. relinings and rebasings of Dentures.
20. implants and implant supported prosthetics including, but not limited to any related surgery, placement, restorations, maintenance, and removal.
21. oral surgery except as specified elsewhere as a covered service.
22. diagnosis and treatment of temporomandibular joint (TMJ) disorders.
23. general anesthesia or intravenous sedation.

Dental Insurance: Exclusions (continued)

24. consultations.
25. application of desensitizing agents and occlusal adjustment.
26. fixed and removable appliances for correction of harmful habits.
27. appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
28. initial installation of a Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
29. implants and implant supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
30. duplicate prosthetic devices or appliances.
31. replacement of a lost or stolen appliance or crown, inlay/onlay, or Denture.

Transplant Exclusions And Limitations

In addition to the provisions of the Group Policy titled "MEDICAL INSURANCE: EXCLUSIONS" and "GENERAL LIMITATIONS", the following will apply solely to the benefits afforded under Transplants:

We will not pay Transplant benefits for charges incurred for:

1. acquiring the organ for the purposes of storage or harvesting without the expectation of an immediate transplant for an existing Sickness. However, such harvesting and/or storage of bone marrow, tissue or stem cells, is covered if the transplant is expected to occur within twelve months for an existing Sickness.
2. xenotransplantation.
3. transplant of partial pancreatic tissue or islet cells under the context of a Clinical Trial.
4. transplants performed at a facility that does not meet the prerequisite local or regional accreditation requirements.
5. experimental and investigational services which include but are not limited to the following:
    a) In kidney transplants:
        i. gene microarrays and measurement of cytokines and tumor necrosis factors for diagnosis of acute renal allograft rejection;
        ii. urine immunocytology for T cells, measurement of pre-transplantation soluble CD30 level for diagnosing acute kidney rejection;
        iii. belatacept when used as a prophylaxis for prevention of organ/tissue rejection other than for kidney;
        iv. human leukocyte antigen-G-14-base-pair-insertion/deletion polymorphism for evaluating the risk of developing kidney graft rejection;
        v. equine antithymocyte immune globulin other than for prophylaxis or management of allograft rejection episodes in kidney transplants; and
        vi. aplastic anemia;
    b) In liver transplants:
        i. bioartificial, ectopic, and hepatocellular liver transplants;
    c) In heart transplants:
        i. the use of a total artificial heart as permanent treatment as an alternative to a heart transplant;
        ii. heartsbreath test – to diagnose rejection;

Transplant Exclusions And Limitations (continued)

iii. allomap gene expression profile for monitoring rejection in recipients more than six months past procedure;

iv. cytokine gene polymorphism for evaluating rejection;

d) In intestinal transplants:
   i. multi-visceral transplants for individuals with neuroendocrine pancreatic tumors;

e) In corneal grafts:
   i. when combined HLA-matched limbal stem cells allograft with amniotic membrane is used as a prophylactic approach to prevent corneal graft rejection following penetrating keratoplasty;
   ii. when used for indications other than total loss of stem cells including, but not limited to, chemical/thermal injuries, Steven Johnson syndrome, following surgeries or cryotherapies to limbal region, contact lens induced keratopathy or hypofunction of stem cells;

f) In autologous chondrocyte implants:
   i. for patellar/talar lesions, and lesions of joints other than the knee;
   ii. matrix-induced chondrocyte implantation including the use of Bio-Gide (resorbable bilayer membrane made of porcine collagen) for the treatment of osteochondral defects/lesions and all other indications;
   iii. combined meniscal allograft and autologous chondrocyte implantation of the knee;
   iv. hybrid autologous chondrocyte implant performed with osteochondral autograft transfer system (Hybrid ACI/OATS) technique;
   v. non-autologous mosaicplasty using resorbable synthetic bone filler materials (including but not limited to plugs and granules);
   vi. use of minced articular cartilage (whether synthetic, allograft or autograft);
   vii. use of synthetic resorbable polymers including, but not limited to, PolyGraft BGS, TruFit, TruGraft) to repair osteochondral articular cartilage defects;

g) In stem cell transplants:
   i. harvesting, freezing, storage of umbilical cord blood of non-diseased persons for possible future use.

6. services related to organ procurement from a cadaver or a live donor, other than the costs for surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor.
7. donor expenses directly related to or as a result of organ donation which occur more than thirty days after surgery.
8. re-transplantation when evidence exists that patient non-compliance with treatment recommendations was a significant contributor to transplant failure.

Infertility Exclusions And Limitations

In addition to the provisions of the Group Policy titled “MEDICAL INSURANCE: EXCLUSIONS” and “GENERAL LIMITATIONS”, the following will apply solely to the benefits afforded under the Infertility Benefits:

We will not pay Infertility benefits for charges incurred for:

1. commercially available over-the-counter home ovulation prediction tests or pregnancy kits.
2. experimental and investigational Infertility services including, but not limited to,:
   a) immunological testing including, but not limited to, Antiphospholipid, embryotoxicity assays, reproductive immunophenotype (RIP), circulating natural killer cell measurement, Th1 and Th2 intracellular cytokine assay or antiprothrombin antibodies;
   b) uterine and endometrial receptivity testing including, but not limited to, Endometrial function tests, E-tegrity, Beta-3 integrin test etc.);

c) sperm DNA integrity testing including, but not limited to, Sperm Chromatin structure assay, TUNEL assay, Comet assay, human sperm activation assay, sperm DNA fragmentation assays or sperm DNA decondensation;

d) ovarian reserve testing including, but not limited to, Serum inhibitin B measurement or anti-mullerian hormone testing;

e) hemizona test;

f) computer assisted sperm motion analysis;

g) reactive oxygen species testing (ROS);

h) in vitro testing of sperm penetration;

i) DHEA and FSH manipulation;

j) hyaluronan binding assay;

k) manual soft tissue therapy for the treatment of pelvic adhesions including, but not limited to, WURN technique or clear passage therapy;

l) immune treatments including, but not limited to, preimplantation glucocorticoids, anti-tumor necrosis factor agents, leucocyte immunizations or IV immunoglobulins;

m) direct intraperitoneal insemination, intrafollicular insemination, fallopian tube sperm transfusion;

n) laser assisted necrotic blastomere removal from cryopreserved embryos; or

o) HCG, hMG, urofollitropin and recombinant follitropins, Follistim and Follistim AQ for idiopathic male infertility (i.e. for those without documented hypogonadotropic hypogonadism, idiopathic microphallus and all other indications in males).

3. cryostorage/cryopreservation of sperm, eggs or embryo when not undergoing covered active Infertility treatment.
4. cryopreservation of immature eggs.
5. testicular tissue or testis xenografting.
6. services when either of the partners has had a previous sterilization procedure, with or without surgical reversal and in females who have undergone a hysterectomy. Individuals who have undergone gender reassignment surgery are considered to have undergone elective sterilization and are therefore not considered eligible.
7. any treatment for infertility in absence of an associated diagnosis.
8. egg retrievals greater than six per lifetime.
9. IVF not performed by a Physician who conforms to the guidelines of the American Society for Reproductive Medicine and American Congress of Obstetricians or the appropriate medical specialty society in the corresponding jurisdiction.
10. egg retrievals completed after the age of 45.
11. IVF transfers completed after the age of 50.
12. IVF where You or Your Insured Dependent have not made a reasonable effort through less costly procedures to obtain a successful pregnancy. Reasonable effort is defined as no more than 3 treatment cycles of ovulation induction or intrauterine inseminations. This exclusion shall not apply if a Physician has determined IVF to be Medically Necessary for You or Your Insured Dependent.

General Limitations

We will not pay benefits under the Group Policy for charges incurred for:

1. an Injury arising out of, or in the course of, any employment for wage or profit, including self-employment;.
2. a Sickness for which You or Your Insured Dependents are entitled to benefits under any workers' compensation or similar law.
3. services or supplies received by You or Your Insured Dependents before insurance starts for that person.
4. completion of claim forms when charged by a provider.
5. by You or Your Insured Dependents that are reimbursed, entitled to reimbursement, or are in any way indemnified by any personal injury protection benefits payable under any group or individual automobile "no-fault" insurance policy.
6. care or treatment of any Sickness or Injury that results from war, declared or undeclared, or any act of war.
7. care or treatment of any Sickness or Injury that results from committing or attempting to commit an assault or felony.
8. care or treatment of any Sickness or Injury that results from any intentionally self-inflicted Injury.
9. care or treatment to the extent that payment under the Group Policy is prohibited by any law of the jurisdiction in which You or Your Insured Dependents reside at the time the charges are incurred.
10. which You or Your Insured Dependents are not legally required to pay.
11. which would not have been made if no insurance coverage had existed.
12. services and supplies which are in excess of the lesser of: (a) the Reasonable and Customary Charge; or (b) the Maximum Allowed Charge.
13. services and supplies that are not Medically Necessary.
14. services and supplies that are not Dentally Necessary.
15. vitamins, food supplements or for experimental drugs or drugs limited by law to investigational use and any charges for the administration of such substances (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections which are covered.).
16. drugs that are not approved by the Food and Drug Administration (FDA).
17. experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society in the corresponding jurisdiction.
18. treatment, services or supplies received in a Hospital owned and operated by any government.
19. private duty nursing services in a Hospital or any other facility.
20. reversal of gender reassignment surgery.
21. Custodial Care, education or training.
22. services that are reimbursed, entitled to reimbursement, or are in any way indemnified by or through any public program, other than Medicaid by You or Your Insured Dependents. For the purpose of this limitation, any individual who, at any time, was entitled to enroll in any portion of the medical care program under Title XVIII of the Social Security Act of 1965, but did not enroll, for any reason, will only receive reimbursement in an amount equal to that of which he or she would have been entitled, if any, if he or she had enrolled.
23. services rendered by a member of Your or Your Insured Dependents' Immediate Family.
24. reversal of a voluntary surgical sterilization.

DISCLAIMER

This schedule of benefits is intended as a guideline and does not modify in any manner the terms and conditions specified in the policy document. In case of discrepancy between this document and the actual policy contract, the terms and conditions of the policy contract shall prevail. It should always be used in conjunction with the actual policy contract.