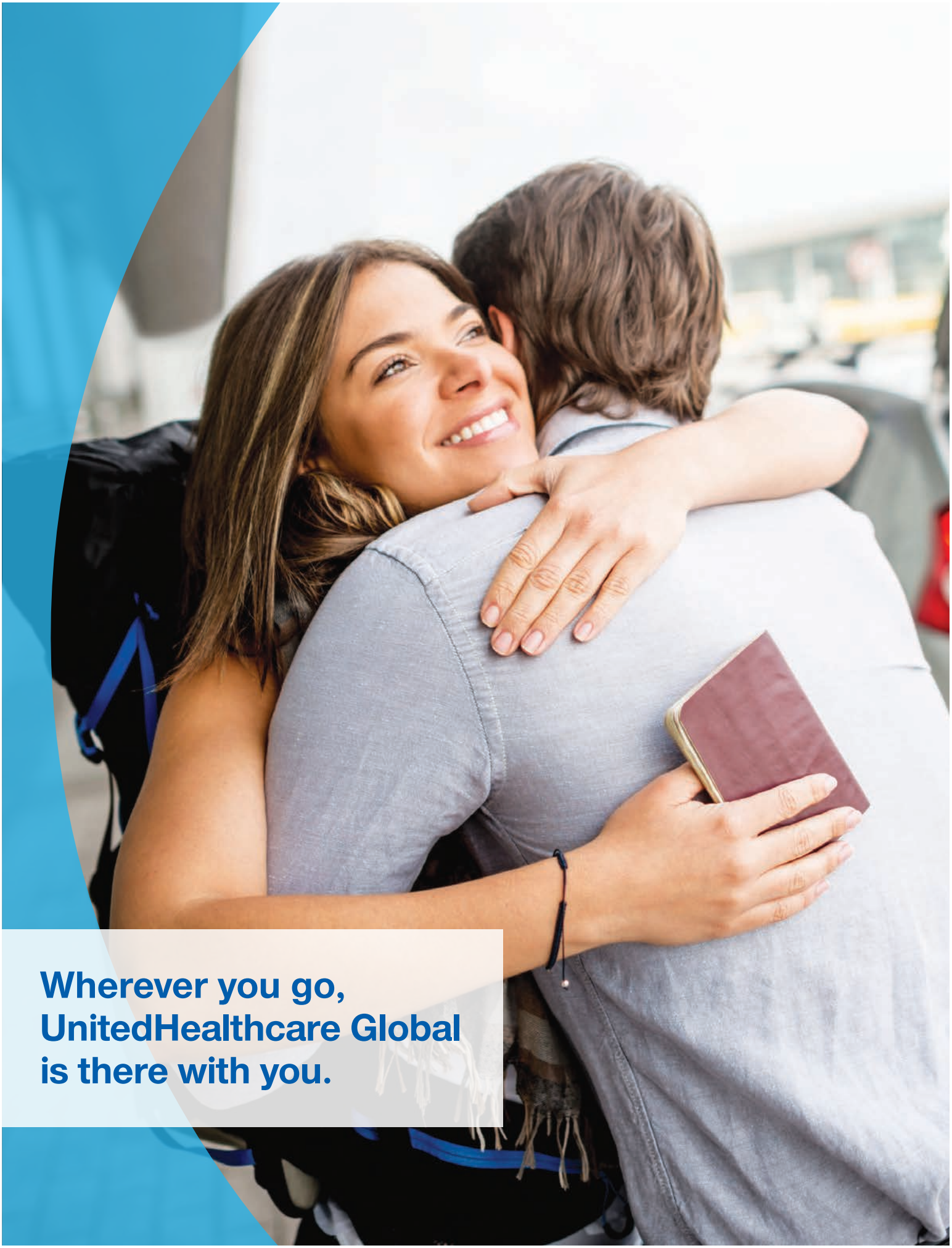
Welcome to your global health benefits.

The Hertz Corporation

UnitedHealthcare® Global



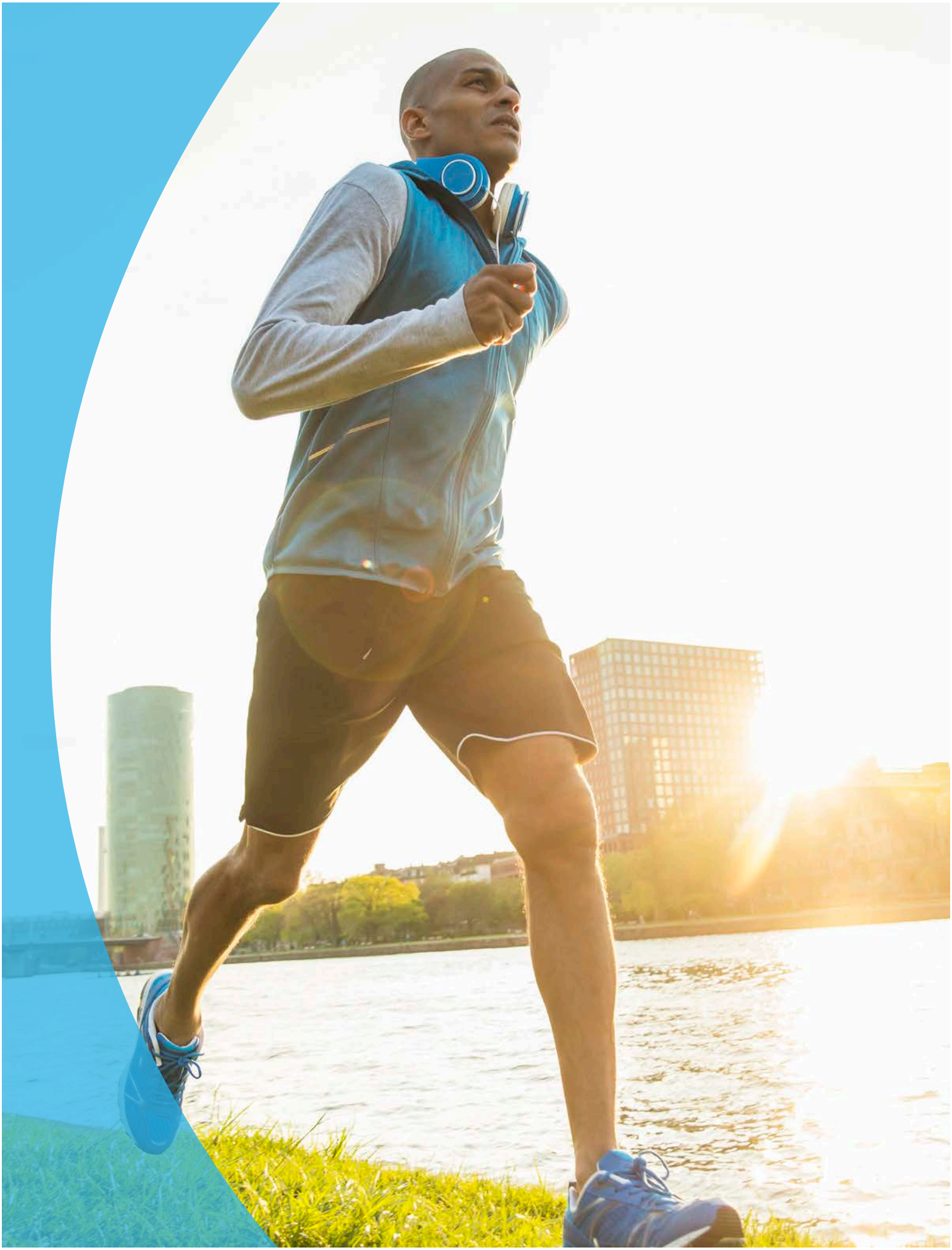
Wherever you go, UnitedHealthcare Global is there with you.

Your plan is as mobile as you are.

No matter where your assignment takes you, you have access to the health care resources you need. Your UnitedHealthcare Global insurance plan works efficiently and simply, wherever you are in the world.

Health care can be complicated, so this guide is designed to make it simple. Facts and tips are organized into sections that guide you through everything you need to know. We suggest you read through the guide once and then save it for future reference.

What's inside:

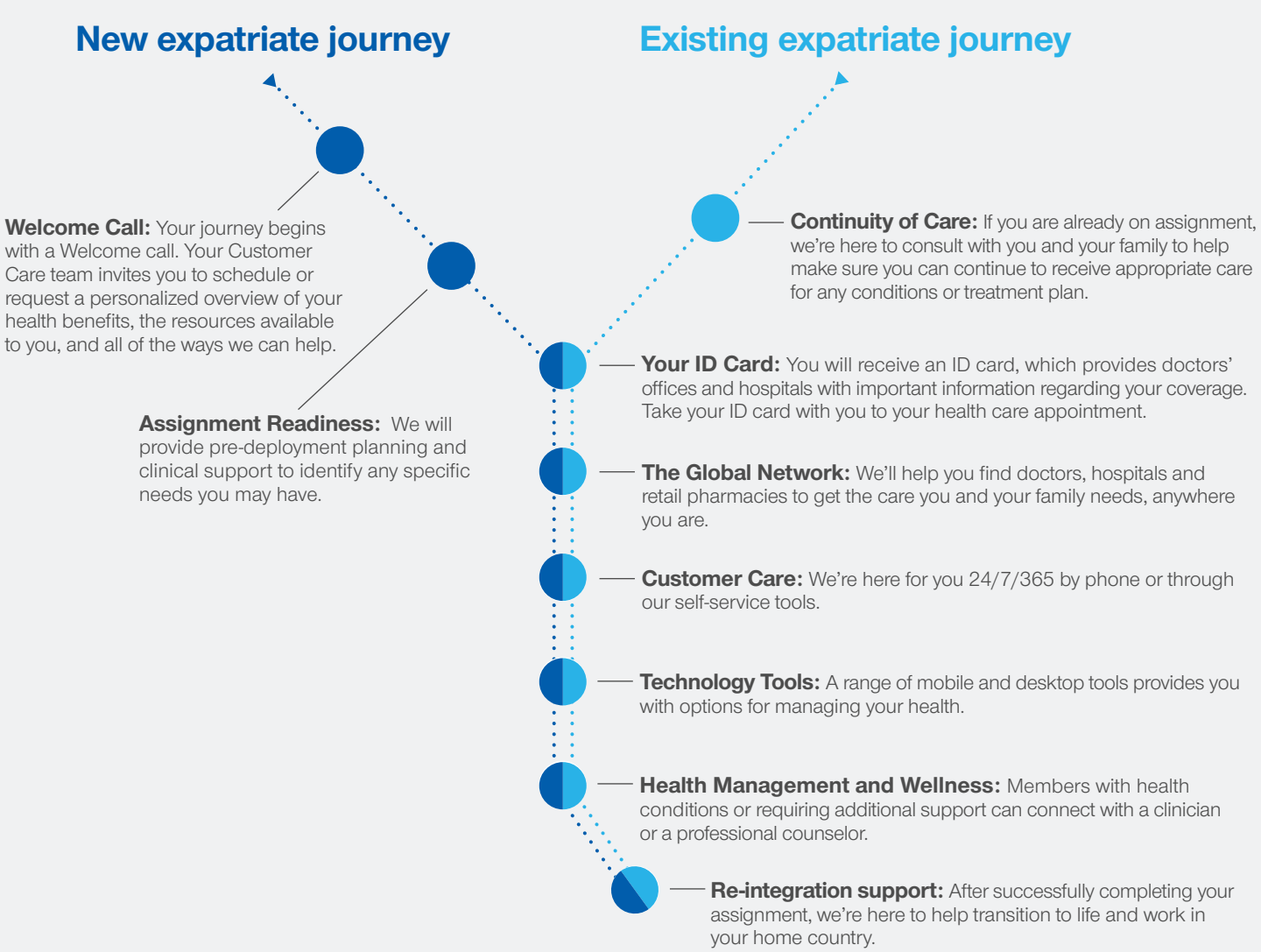


1 Get Started

Your expatriate journey

Helping you navigate

Adjusting to life as an expatriate and accessing health care while on assignment can be more challenging than at home. UnitedHealthcare Global is providing this welcome information and additional resources to make sure you have the support you need, every step of the journey. We'll help you navigate the health system in your host country and overcome language or cultural barriers. We're also here to help your covered family members, who may not have made the journey with you.



Your medical ID card, one website, one number to call

Review your medical ID card

Always keep your ID card with you.

Your ID card contains valuable information about your coverage, so it's important to know what everything means.

1. **Member ID:** Identifies you as a covered individual and is how we keep track of your benefit usage. When you call Customer Care, you will be asked for this number.
2. **Group number:** Identifies your employer and your plan.
3. **Member:** The name of the person who carries the plan.
4. **Dependents:** Names of everyone covered under the plan.
5. **Office:** Amount you owe at a primary care physician visit.
6. **ER:** Amount you owe at an emergency room visit.
7. **UrgCare:** Amount you owe at a visit to an urgent care center.
8. **Spec:** Amount you owe at a specialist visit.
9. **Rx Bin & Rx Grp:** Identifies you as a UnitedHealthcare member for OptumRx prescription drug administration in the U.S.
10. **myuhc.com**: Your member website, where you can manage your benefits.
11. **+1.877.844.0280:** 24/7 Customer Care number to call.

Register at myuhc.com

It's your direct connection, day and night.

Use your secure web portal to find information and tools to help you get the most out of your benefits.

- **See what's covered**
- **Find a network doctor, clinic or hospital**
- **Submit and track claims**
- **Translate medical and pharmacy terms**
- **Get a replacement for your member ID card**
- **And much, much more**

Registration is easy.

Registering at **myuhc.com** will give you one universal login – your HealthSafe ID – that you can use on **myuhc.com,** or on the **Health4Me®** smartphone app.

Have your ID card ready (or you can use your Social Security Number if you have one and date of birth) and then:

1. **Go to** www.myuhc.com
2. **Select Register Now**
3. **Follow the step-by-step instructions -** you will be guided along the way with helpful onscreen feedback. Remember to sign up for paperless communications, which allow us to communicate important updates to you via email.

If you have previously registered for myuhc.com as a UnitedHealthcare member, you will need to register again for access to your UnitedHealthcare Global benefits and information.

One password is all you need.

Register at myuhc.com, and use the same HealthSafe ID username and password to log in to:

- **myuhc.com** health benefits portal
- **Health4Me** mobile application

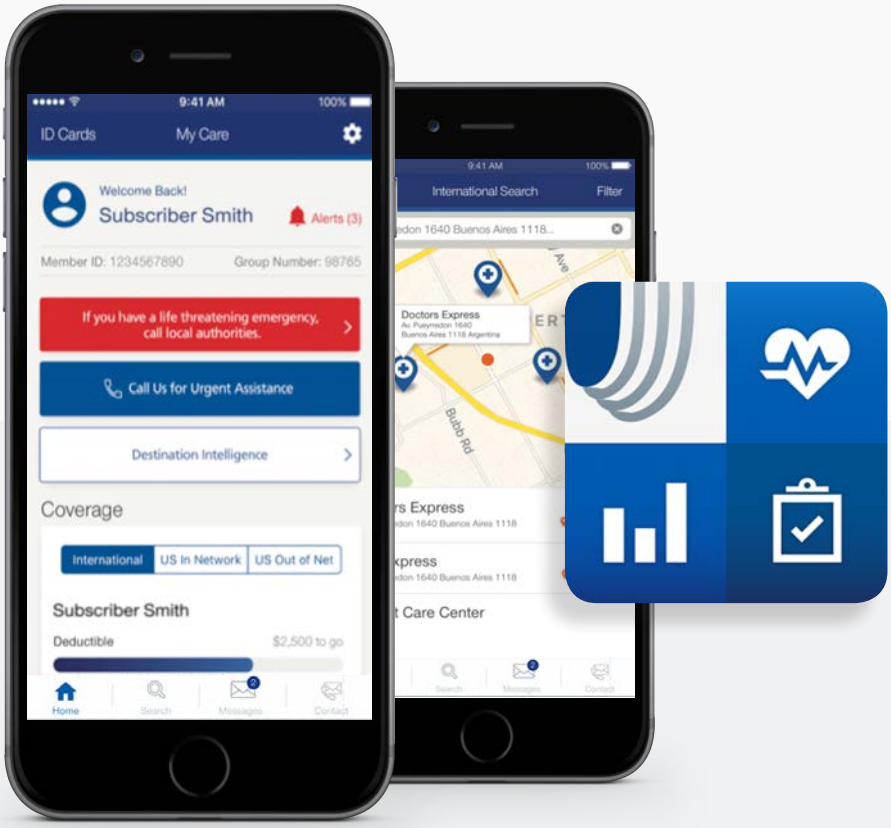
Download the Health4Me® mobile app

You can do so much with Health4Me

With mobile functionality designed especially for expatriates, the award-winning Health4Me app travels with you, wherever you are. You can download it from the App Store® or Google Play™ in the U.S., Singapore, and the United Arab Emirates. Once downloaded, it works around the world.

Use the same credentials you use to log in to myuhc.com. Then:

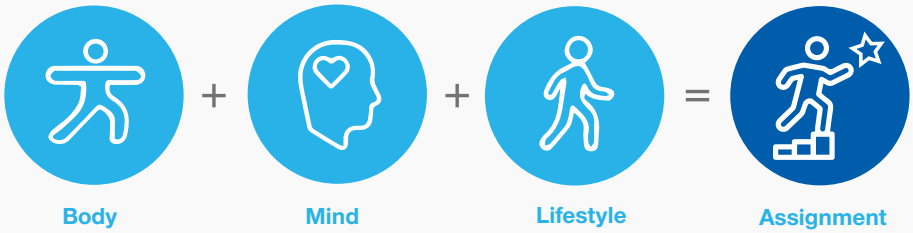
- **Find a doctor, hospital or clinic nearby**
- **Identify providers who accept direct payments from UnitedHealthcare Global**
- **View recent medical and security alerts globally or by country**
- **Subscribe to receive future medical and security alerts for up to 10 countries, including your current GPS location of the mobile device**
- **Call us for urgent help with one touch**
- **Review your coverage**
- **Upload and track claims**
- **Share your ID card with your doctor**

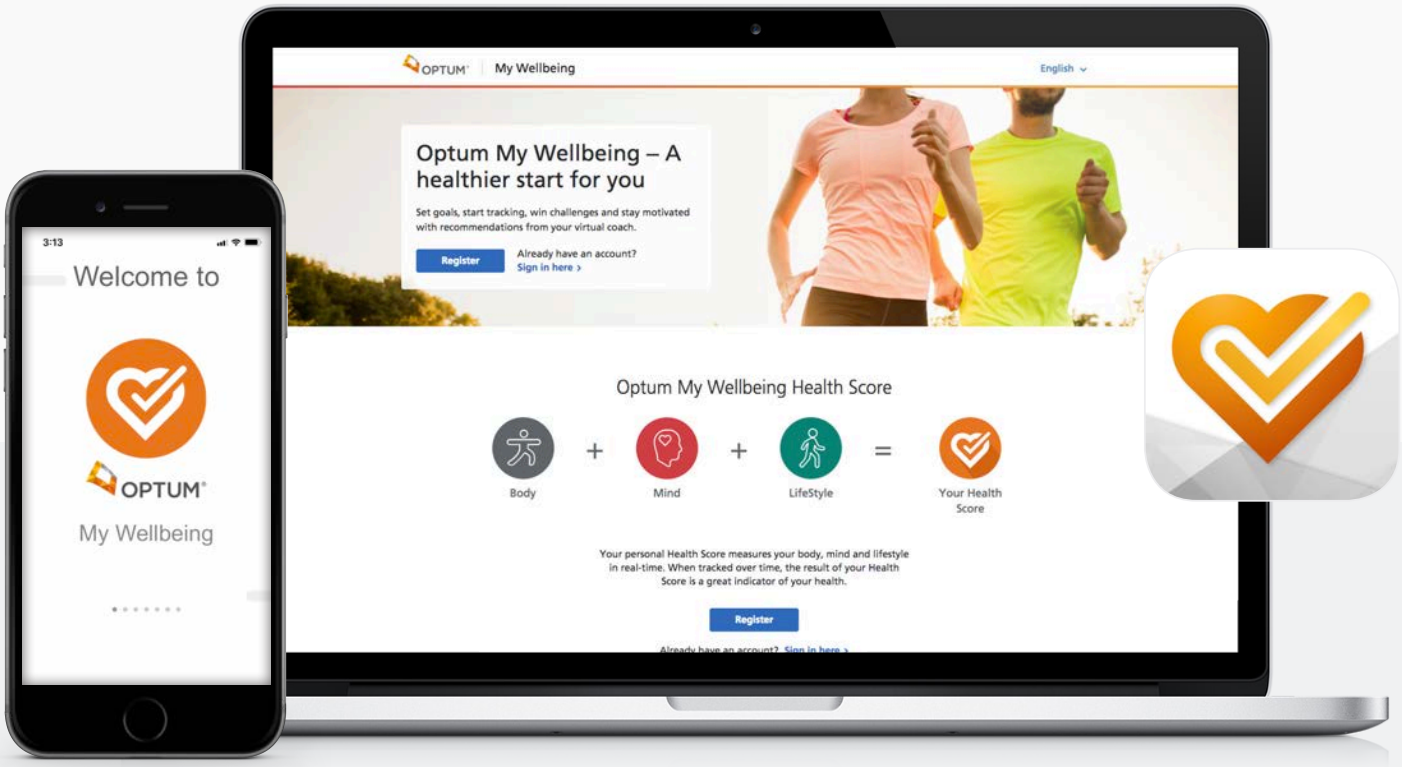


My Wellbeing

For a healthier journey

My Wellbeing is a digital health platform provided by Optum®, a UnitedHealth Group® company, designed to help you and your dependents create and sustain positive behavioral changes and inspire the development of healthy habits for life.





My Wellbeing (cont.)

Personalized Goals and Challenges

- Set personal goals
- Join online group activity challenges
- Choose from social, physical or nutrition programs

Real-time Health and Activity Tracking

- Discover your Health Score and use it to track your results to achieve your goals
- Get support from a virtual coach

Stay Connected, Stay Focused

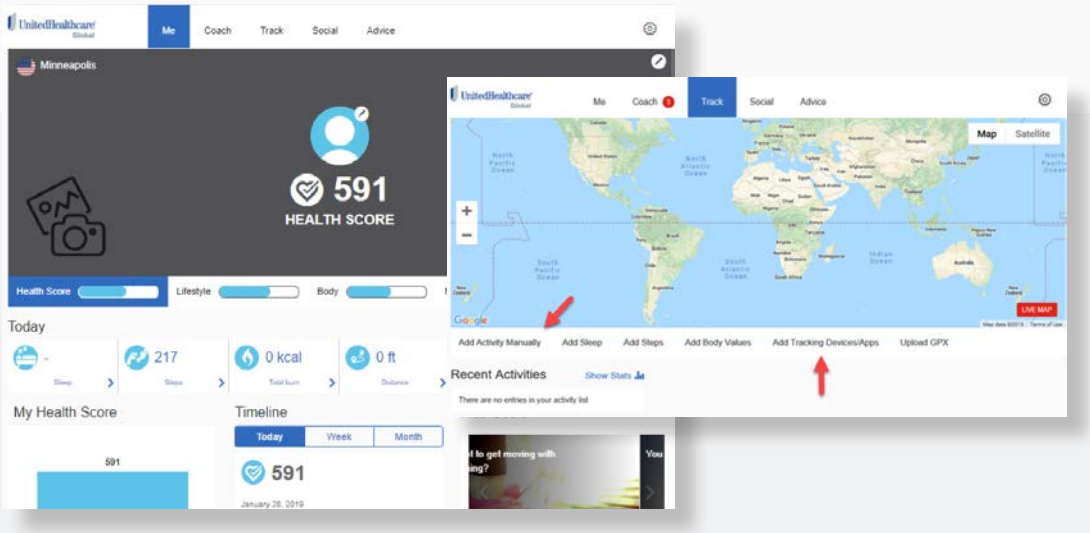
- Get inspired and focused with online communities
- Receive timely coach check-ins and reminders that can help you set goals and stay inspired
- Support available in 12 languages

Seamlessly Connected

- Easily accessed by smartphone or online
- Connects to health-related devices and apps, such as heartrate and blood pressure trackers

Available at **mywellbeingsolution.com.**
Enter Company Access Code **uhcglobal**.

Download the **Optum My Wellbeing app** from your favorite app store.



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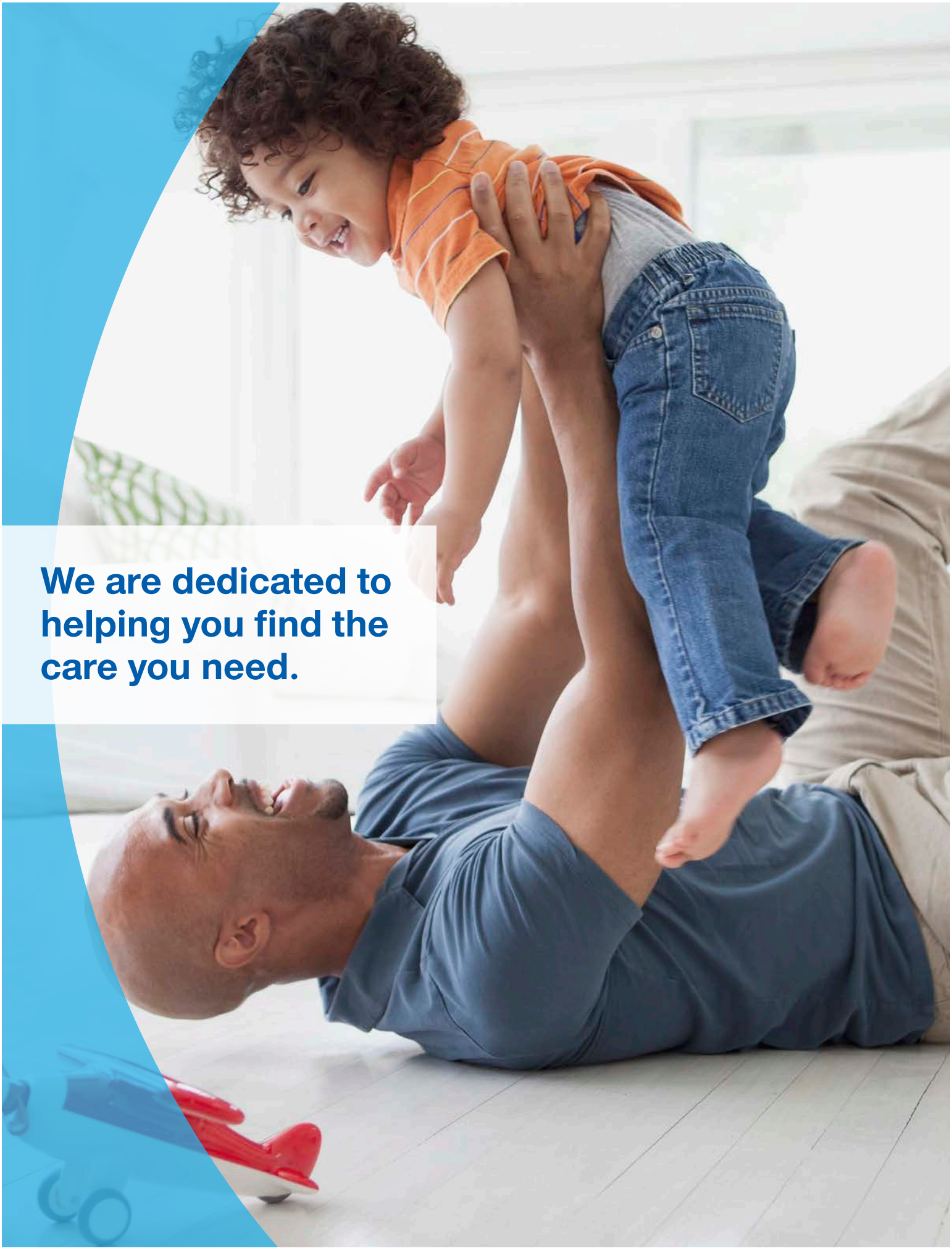


We are dedicated to helping you find the care you need.

Quality care, direct payment

When you need care

Your plan provides access to a global network of health professionals, hospitals, clinics and diagnostic facilities so that you can get the care you need at home or on assignment.

Visit myuhc.com:

- For **International Provider searches** select: View Global > Find an International Provider > then enter information about your location and the type of care we can help you find
- For **U.S. provider searches**, select: View United States > Find A Doctor

Outside the U.S. and Canada:

- Call the Direct Access Number for the country from which you are calling. Visit **https://www.business.att.com/bt/access.jsp** for a list of direct access codes by country. At the prompt, dial **+1.877.844.0280**.
- If your country isn't listed, call **+1.763.274.7362**.

In the U.S. or Canada:

Toll-free **+1.877.844.0280**

Is it an emergency?

Follow the **"first call"** protocol for the country you are in. For instance, in the U.S., that means "Call 911." The Health4Me smartphone app displays the local emergency numbers for most countries worldwide.

Visit **https://travel.state.gov/content/dam/students-abroad/pdfs/911_ABROAD.pdf** for a list of global first protocol numbers.

When you need care

Direct Payment System

UnitedHealthcare Global has set up a direct payment system with our global network providers. This means health care bills come to us for payment, minimizing your out-of-pocket expenses. There may be some circumstances in which you need care from a provider who does not have an existing direct payment agreement with UnitedHealthcare Global. If that happens, call Customer Care. In many cases, we can arrange direct payment.

Virtual Visits

Seeing a doctor at home and on assignment should be simple. That's why we are pleased to offer Virtual Visits as part of your UnitedHealthcare Global benefits program.

Whenever you need care – day or night – Virtual Visits from UnitedHealthcare Global can be a great option. From treating colds and fevers, to caring for migraines and allergies, use the website or mobile app* to connect with a doctor.

- **Real time visits with medical professionals**
- **Physicians who can diagnose and prescribe****
- **Health care beyond normal clinic hours**
- **More time at work, not time driving to or waiting for an office visit**

Register for Virtual Visits:

Inside the United States visit: uhc.com/virtualvisits

Outside the United States visit: babylonhealth.com/uhcg

*Outside the U.S., the Babylon app cannot be downloaded from the Apple App Store in Australia, Canada, China, Kenya, Nigeria or from outside the U.S., the Babylon app cannot be downloaded from the Google Play Store in Australia, Canada, China, or Rwanda. Cellular messaging and data rates may apply.

**Prescription services for U.S. services may not be available in all states. Prescription services for non-U.S., international virtual visits are only available in the European Economic Area (EEA) and Switzerland.

Submit claims

UnitedHealthcare Global will make sure your claims are paid quickly and accurately, no matter where you are. At **myuhc.com**, you can submit claims online and see your claims history.

Four ways to submit a claim:

ONLINE at myuhc.com:

For International claims: Select "View Global" and then "Submit a Claim," then provide details regarding the health care visit on the New Claim form

MOBILE:

Via the **Health4Me app** on your smartphone.

MAIL:

UnitedHealthcare Global Insurance
P.O. Box 740111
Atlanta, GA 30374-0111

FAX:

Outside the U.S. or Canada:
Call the Direct Access Number for the country from which you are calling. Visit **https://www.business.att.com/bt/access.jsp** for a list of direct access codes by country. At the prompt, dial **+1.877.370.4150.**

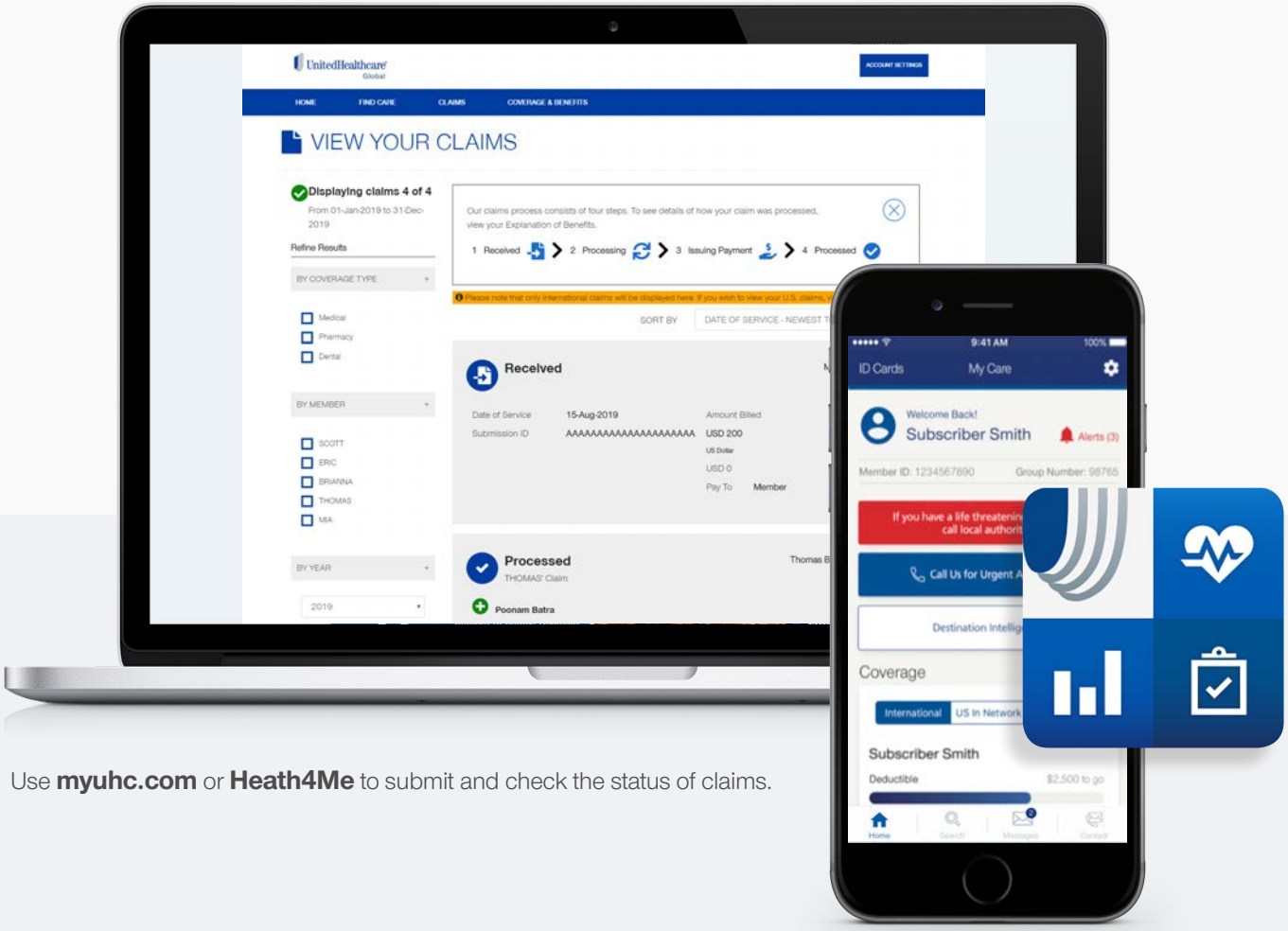
In the U.S. or Canada:

Toll-free **+1.877.370.4150** or **+1.813.870.0796**

A copy of the claim form is included with this kit. You can download a claim form at **myuhc.com** (available in multiple languages).

Check the status of a claim

It's easy. To check on the status of a claim, visit **myuhc.com** or the **Health4Me** app on your smartphone. You can also reference your past claims history.



Use **myuhc.com** or **Heath4Me** to submit and check the status of claims.

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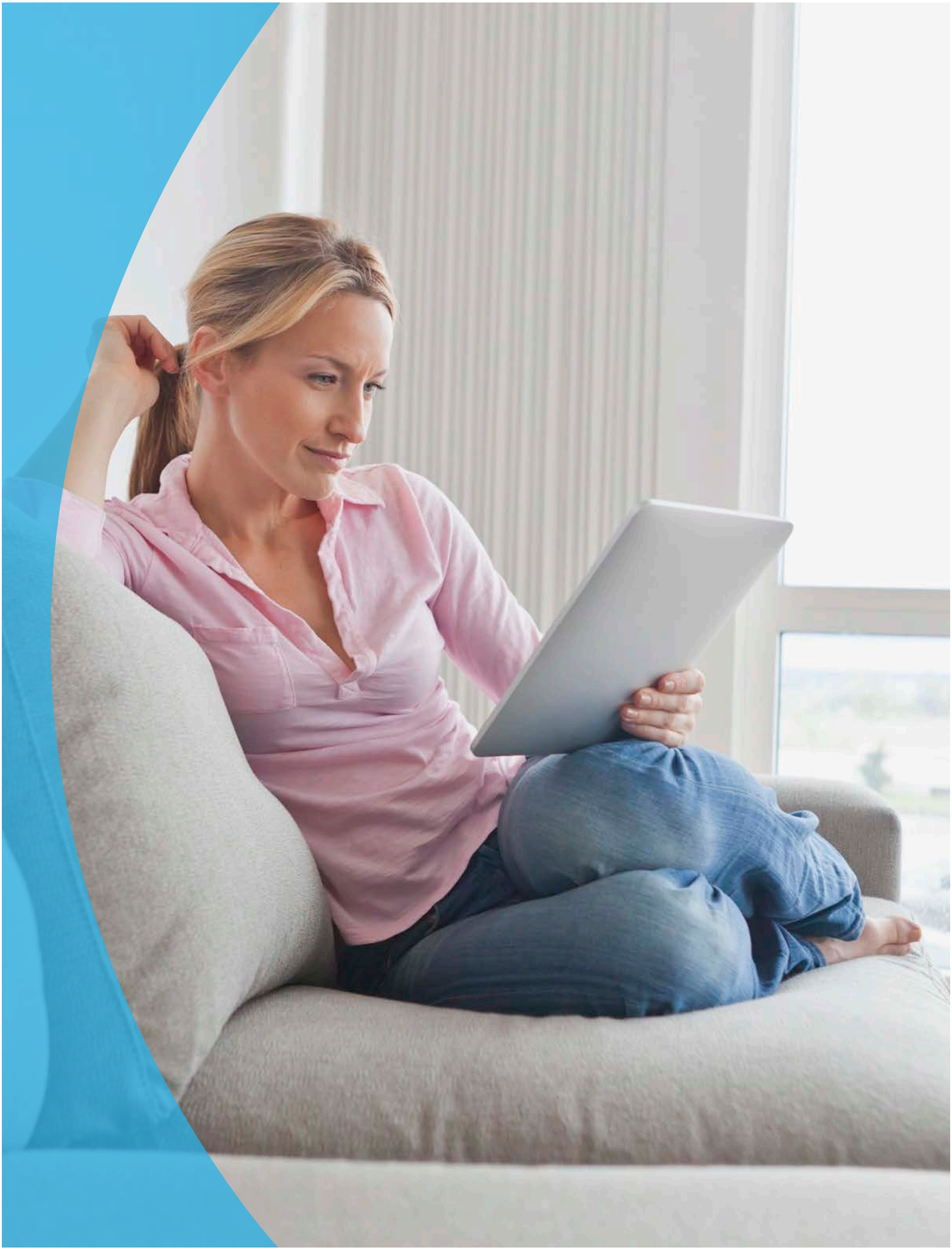


Safe and easy medication management

Getting your prescriptions

OptumRx is your plan's pharmacy benefits manager and works to offer safe, easy and cost-effective ways for you to get the medication you need. Show your member ID card at retail pharmacies in the U.S. to limit your out-of-pocket expenses

OptumRx also offers the convenience of receiving prescription medications delivered to your U.S. address. You can order a three-month supply, often with a reduced copayment compared to copay at retail pharmacies. U.S. federal regulations prohibit shipment of prescription medications outside the U.S., Puerto Rico and Guam.

Filling prescriptions before you leave

You can receive up to a one-year supply of prescription medication. Call **Customer Care** before you go to get help filling your prescriptions prior to departure or at retail pharmacies in your host country. OptumRx will help determine if your medication is suitable for long-term supply and how it should be stored.

In the U.S., Puerto Rico and Guam, you and covered family members can fill prescriptions at more than 67,000 in-network retail pharmacies. Locate pharmacies at **myuhc.com** or call **Customer Care** for help.

Buying prescriptions abroad

Because U.S. federal regulations prohibit shipment of prescription medication outside of the U.S., Puerto Rico and Guam, it's best to fill your prescriptions at local retail pharmacies while on assignment. Call **Customer Care** for help in finding retail pharmacies nearby. You can pay for your medication and submit a claim to us for reimbursement.

What if the medication name is different?

Medication names and strengths can vary from country to country. Visit **myuhc.com** to see drug name translations and get detailed information on medications. Call **Customer Care** for help in understanding medication differences and your benefits.

A few things to note:

- Your plan covers prescription medication only. Pharmacy benefits will not apply if your medication is available over-the-counter in the host country.
- If you can't get a specific medication in another country, there may be a comparable option. Discuss this with your doctor ahead of time so you are prepared.

Reach customer care:

When you need help, our multilingual Customer Care Center is here to support you.

PHONE:

Outside the U.S. or Canada:
Call the Direct Access Number for the country from which you are calling. Visit **https://www.business.att.com/bt/access.jsp** for a list of direct access codes by country. At the prompt, dial **+1.877.844.0280.**

If your country isn't listed, call **+1.763.274.7362.**

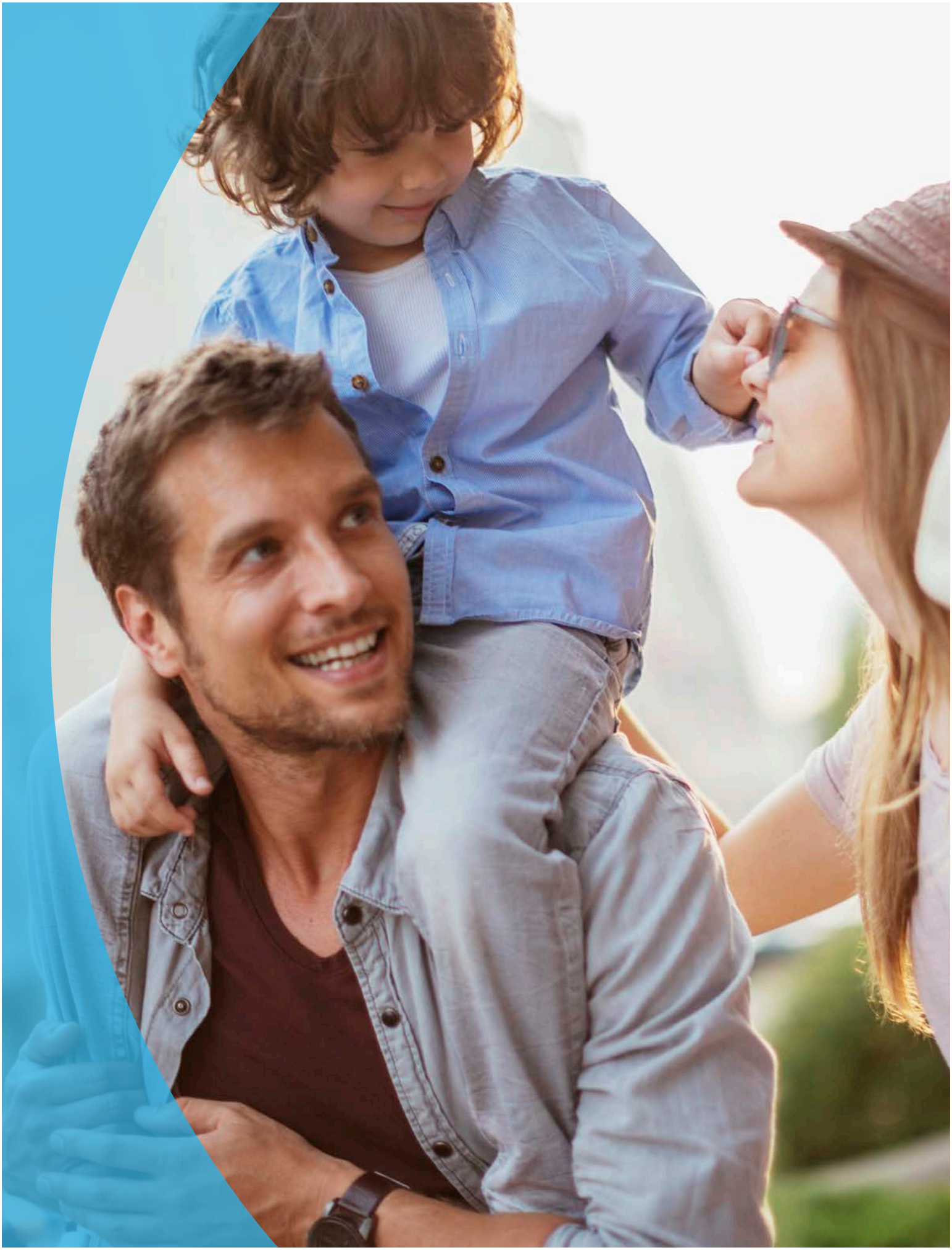
In the U.S. or Canada:
Toll-free **+1.877.844.0280**

EMAIL:

To send emails securely to our team:
Log onto **myuhc.com**, select > Message Center

Alternatively, for general queries, email us at:
expatinsurance_memberservices@uhcglobal.com
Note: You can also chat with customer services at any time once logged onto myuhc.com.

Notes:



More value, more support … it's all part of your plan.

Assistance services

The Customer Care Center is open around the clock to help you in an emergency. Move around the world with confidence, knowing we are here to support you.

Reasons to call.

Get 24/7 assistance in dealing with unforeseen medical and travel situations like:

- **Medical evacuations & repatriations**
- **Provider referral**
- **Payment coordination**
- **Device and prescription transfer**
- **Document replacement**
- **Emergency travel assistance**
- **Legal referrals**

Call for help:

Outside the U.S. or Canada:
Call the Direct Access Number for the country from which you are calling. Visit **https://www.business.att.com/bt/access.jsp** for a list of direct access codes by country. At the prompt, dial **+1.877.844.0280.**

If your country isn't listed, call **+1.763.274.7362.**

In the U.S. or Canada:
Toll-free **+1.877.844.0280**

Health management and wellness services

Living and working in another country can be challenging. You may experience situations you have never had to address before. Our goal is to make sure you have the resources you need to get acclimated to your new environment and to succeed.

Welcome call

You can schedule or request a welcome call from an experienced team member at UnitedHealthcare Global Customer Care. They will give you a short background on UnitedHealthcare and how we can help. They also will confirm or collect your email address so we can connect with you in case we need to reach you during your assignment. This is your time to share any concerns you or your family have while you are on assignment.

Health Management Program

UnitedHealthcare Global offers the Health Management program to all covered expatriates and their families to help you access the resources you need to manage your health and chronic conditions, whether at home or on global assignment in an unfamiliar location.

The UnitedHealthcare Global Health Management program focuses on the specific needs of you and your family, wherever you are in the world. Clinicians provide targeted support and assistance and help expatriate families overcome the challenges of accessing care and resources for complex, high risk conditions. These clinicians develop a trusting relationship with program participants, getting to know their case history and needs on a personal level to help members and their families manage their health and successfully complete expatriate assignments.

The Health Management program is designed and staffed especially for expatriate populations, with focus on alleviating health-related anxieties for members and their families.

The Health Management program leverages UnitedHealthcare Global's expertise in culture, language and health care intelligence, enabling the clinicians to:

- **Identify and engage high risk individuals and families**

- **Assess the member's unique needs**
- **Assist you in navigating complex health systems in your home and host counties**
- **Facilitate continuity of care**
- **Reduce the risk of complications**
- **Promote improved clinical outcomes**

The program provides expatriate families with a clinician who will help identify solutions to alleviate medical issues, empowering you to:

- **Adapt to any changes in your clinical condition or situation**
- **Consistently stay on your medication or treatment plan**
- **Optimally manage your health**
- **Remain focused, productive and on assignment**

The UnitedHealthcare Global clinical team identifies members who may benefit from the Health Management program. Referral sources range from member self identification (i.e. pre-trip planning, continuity of care needs identification, requests for medical assistance) as well as utilization reviews by our clinical team including data indicators.

Clinicians outreach to you and begin to develop in-depth knowledge of your health issues, identify challenges and barriers to care, and develop strategies to optimize health. The cornerstone of this relationship is personal interaction and the development of an ongoing trusting relationship.

Health care professionals support participants' health needs in 5 areas of focus:

- **Medication management**
- **Durable medical equipment and supplies**
- **Dietary management**
- **Specialty providers for high impact conditions**
- **Action planning for urgent needs**

The Health Management program helps members with the following chronic conditions and more:

- **Diabetes**
- **Coronary artery disease**
- **Hypertension**
- **Back pain**
- **Asthma**

- **Chronic obstructive pulmonary disease (COPD)**
- **Cancer**
- **Chronic disease**
  (i.e. Multiple Sclerosis, Parkinson's, End-Stage Renal Disease, Chron's)
- **High-risk obstetrics (OB)**
- **Premature infant**
- **Human Immunodeficiency Virus (HIV)**
- **Traumatic brain injury**
- **Stroke**
- **Renal failure/kidney disease**
- **Special needs of children**

International Employee Assistance Program (IEAP)

The challenges you face each day can overwhelm you. Your home life, your happiness and your performance at work all can suffer. We're here to help. Your International Employee Assistance Program provides support for those everyday challenges and for more serious problems. It's available around the clock anytime you need it.

You may be struggling with stress at work, seeking financial or legal advice, or coping with the death of a loved one. Maybe you just want to strengthen your relationship with your family. Your IEAP offers assistance and support for these concerns and more:

- **Depression, anxiety and stress**
- **Substance abuse**
- **Problems or conflicts at work**
- **Parenting and family struggles**
- **Financial or legal issues**
- **Isolation and loneliness**
- **Culture shock**
- **Re-integration support**
- **Legal and financial consulting**

We will not share your personal records with your employer or anyone else without your permission. Information about you and the services you use is confidential in accordance with the applicable laws and regulations.

The service is included in your expatriate medical plan. Depending on your needs,

there may be a cost for further help. Any costs will be made clear to you, and you are able to decide whether to proceed. Please refer to your employer benefit plan for further information.

Behavioral Health Services

UnitedHealthcare Global is helping you take steps toward feeling healthier, happier, and more in control of your well-being with behavioral services from Optum's Live and Work Well program.

Benefits include:

- **Access to the latest news, events and library of expert articles and advice**
- **Learn about conditions and issues that may be affecting life**
- **Self-help services**
- **Interactive tools**
- **Talk to a licensed therapist or psychiatrist online**
- **Action-oriented advice**
- **Find a provider**
- **Discover local community and work-life resources**
- **Quickly and confidentially connect to expert guidance regarding conditions and situations**

Live and Work Well program is 100% digital, making it easy, convenient and safe for members to find the support they need to live their best life.

Say goodbye to tobacco

We are committed to your wellness. If you want to kick the habit, we are here to support you. UnitedHealthcare Global covers certain over-the-counter and prescription tobacco cessation medications at $0 cost-share, when you meet the requirements.[1]

How to qualify for tobacco cessation benefits

There are just a few requirements to receive medications at $0 cost-share. You must:

- **Be 18 or older**
- **Try an over-the-counter nicotine product** (covered only if supplied directly from the provider)
- **Get a prescription for a covered tobacco-cessation medication**
- **Fill your prescription at a network pharmacy in the U.S. or submit a claim for reimbursement if you fill your prescription at an international pharmacy.**

Over-the counter medications Covered in the U.S., prior authorization is not required. Not covered outside the U.S.	Nicotine replacement gum Nicotine replacement lozenge Nicotine replacement patch	
Prescription medication Covered globally, prior authorization is not required.	Bupropion sustained-release (generic Zyban) tablet	
	Nicotrol Inhaler Nicotrol Nasal Spray Chantix Tablet	Covered after you have tried: 1) One over-the-counter nicotine product (covered only when purchased at provider's office; not covered at retail pharmacies) and 2) Bupropion sustained-release (generic Zyban) separately

[1] Tobacco cessation coverage at $0 copay is available to members enrolled as part of a fully insured group. Contact UnitedHealthcare Global Customer Care to confirm program eligibility.

Your dental benefits

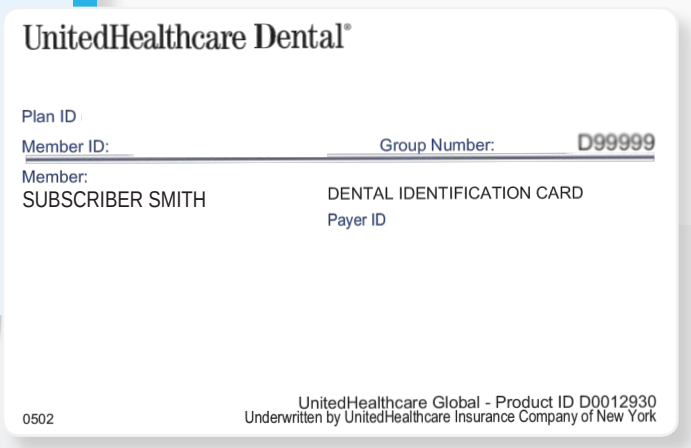
7 key facts about your dental plan

1. You can use the services of any dentist or dental specialist around the world. Call **Customer Care**, and we'll help you find one nearby.
2. In the U.S., you can save money by using a dentist or dental specialist within the UnitedHealthcare National Options PPO 30 network.
3. Need to see a dental specialist? You won't need a referral.
4. Preventive services are covered at little or no cost to you.
5. It's a good idea to get an estimate for dental services that may cost more than $500. Call **Customer Care** so that we can attempt to arrange direct payment with the provider you have selected.
6. To find facts about your dental benefits, log in to **myuhc.com**, your member portal.
7. **Customer Care** is here 24/7 to offer help and answer your questions.

Taking care of your teeth and gums is important to your overall health, wherever you are in the world. Your dental benefits are designed to help you find dentists and specialists nearby so you can get the care you need.

Your Dental ID card

- Use your dental member ID card for your dental needs.
- Bring your dental ID card with you every time you visit a dental office.
- You can always print a copy of your dental member ID card at your member portal, **myuhc.com.**



What your dental plan covers

Preventive services are covered at little or no cost to you, as long as you use a dentist or dental specialist who is part of our network. Preventive care includes:

- **Routine exams**
- **Cleanings**
- **Oral cancer screenings for adults**
- **Sealants for children**
- **Two preventive visits in 12 consecutive months**
- **Extra visits are at no added charge for pregnant women** (ask your dentist to include the name of your obstetrician and your due date on the claim form. We'll take care of the rest).

Other types of care

Your dental plan also covers fillings. Some plans cover only silver fillings for back teeth. If you choose white fillings, you may need to pay the difference. To see how other services are handled, log in to **myuhc.com** and select Plan Information for details.

Tips for choosing dental care

Globally

You are free to seek care from dentists wherever your assignment takes you. We encourage you to call **Customer Care** for help in finding providers nearby. Our team works to set up a direct-pay arrangement with the dental office, which helps keep your expenses lower.

In the United States

Search **myuhc.com** for dentists who participate in the UnitedHealthcare National Options PPO 30 dental network. They have agreed to discount their services for our members by 20 to 30 percent (on average). Dentists who are not part of our network will bill you the difference between what we pay our network dentists and what your dentist typically charges.

Your vision benefits

7 key facts about your vision plan

1. You can use any vision care provider outside of the U.S., using your reimbursement allowance.
2. In the U.S., you can save money by using a vision provider within the UnitedHealthcare network.
3. In the U.S. you also have access to UnitedHealthcare network providers with discounted pricing for laser eye surgery.
4. In-network preventive services are covered at little or no cost to you.
5. It's a good idea to get an estimate for vision services that may cost more than $500.
6. You get a generous frame allowance that applies to virtually any frames on the market.
7. See your specific plan benefits any time at **myuhc.com**.

What your vision plan covers

A comprehensive eye exam can do more than test your vision. It can also identify symptoms of many health problems, such as diabetes, hypertension, high cholesterol, glaucoma and cataracts. Your UnitedHealthcare Global benefits makes it easy for you to give your eyes the attention they deserve.

Log in to **myuhc.com** for a complete description of your vision benefits and to search for providers by zip code, or call **Customer Care**. In general, your benefits include these items:

- **Eye exams:** Covered every 12 to 24 months, depending on your plan. Co-payments may apply.
- **Frames, lenses and contact lenses:** An allowance is provided every 12 to 24 months, depending on your plan. There may be limits on how often you can replace glasses or contact lenses.

Vision coverage details

Location	Exams	Materials
Outside the U.S.	Benefits are paid based on your international medical benefit. For example, if your co-insurance is 100% with $0 deductible, your vision exam will be paid at 100%. If your medical co-insurance is 90% with $0 deductible, your vision exam will be paid at 90% and you will be responsible for the rest.	Benefits will be paid based on your international medical benefit or vision allowance depending on your plan. For example, if your international medical coinsurance is 100% with $0 deductible, then your vision materials (glasses, contacts) will be paid at 100%. If your medical coinsurance is 90% with $0 deductible, then your vision materials (glasses, contacts) will be paid at 90% and you will be responsible for paying the remaining 10%. Or you will receive an allowance for related materials.
U.S. In-network	Covered at your in-network benefit level every 12 or 24 months, depending on your plan.	Every 12 or 24 months (depending on your plan) you will receive an allowance for materials such as frames, lenses and contact lenses. Your costs are lowest when you stay in the network.
U.S. Out-of-network	Covered at your in-network benefit level every 12 or 24 months, depending on your plan. But you will have to pay more out of your pocket.	Every 12 or 24 months (depending on your plan) you will receive an allowance for materials such as frames, lenses and contact lenses. But you will have to pay more out of your pocket.

Preventive care services

Your benefits include preventive care services, including routine tests, pre-assignment immunizations, and screenings. Early detection enables doctors to evaluate treatment options and begin therapies that may reduce complications and the risk of disease progression. This chart displays examples of services that are typically covered. Other screenings may also be covered, up to the limit detailed on your schedule of benefits. Subject to usual & customary as well as country-appropriate guidelines. Log in to **myuhc.com** to view your benefits limits or call **Customer Care**.

Service Category	Tests and Examinations	Service Guidelines
Physical Examination	Review analysis of health questionnaire Physical examination by physician Measurement of blood pressure Height and weight Rectal examination	
Blood Test	BUN, Creatinine T-cholesterol, Triglycerides HDL-cholesterol, LDL-cholesterol Glucose, HbA1c Na, K, Cl CBC (complete blood count) Rubella screening	Rubella screening - child-bearing years.
Hepatitis Panel	Hepatitis B & C	
Urinalysis	Ph, specific gravity, protein, ketones, nitrite glucose occult blood, bilirubin, urobilinogen	
Stool Test	Occult Blood in Stool	
Cancer Screening	Pap smear with HPV – preventive – female only	Recommend for women age 21 or older.
	Mammogram screening – female only	
	Prostate specific antigen (PSA) test – male only	Urologic Society screening recommendations for men less than age 70.
	Screening for lung cancer with low-dose computed tomography	Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Cancer Screening (Choose only one)	Colonoscopy	Recommended starting at age 40-45 if high risk (a personal history of CRC or adenomatous polyp; a genetic syndrome predisposing to CRC (i.e. hereditary nonpolyposis colorectal cancer (HNPCC); familial adenomatous polyposis (FAP), one or more first-degree relatives with CRC; two or more second-degree relatives with CRC; IBD causing pancolitis or longstanding (>8 to 10 years) active disease; certain other clinical situations (such as a personal history of childhood cancer requiring abdominal radiation therapy).
	Sigmoidoscopy	Age 50-75 years, every 5 years combined with high-sensitivity fecal occult blood testing.
	Fecal Immunochemical Test	Age 50-75 years, yearly.
	Fecal DNA	Age 50-75, every 3 years.

More Program Details

1 2 3 4 5

Service Category	Tests and Examinations	Service Guidelines
STD Screening	Chlamydia infection screening Gonorrhea screening HIV screening Syphilis screening HPV (human papilloma virus)	
Behavioral Health Screenings and Counseling	Interventions to reduce alcohol misuse Chemoprevention of breast cancer (counseling) Screening for depression Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors Screening for obesity Behavioral counseling to prevent sexually transmitted infections Counseling and interventions to prevent tobacco use Behavioral counseling to prevent skin cancer Screening for intimate partner violence Counseling regarding prevention of falls in community dwelling adults 65 years or older	
Immunization	Routine immunizations	
Other Screenings and Tests	Abdominal aortic aneurysm (AAA) screening – male only	One-time screening by ultrasonography in men ages 65 to 75 years who have ever smoked.
	Osteoporosis – female only	Women 65 and over.
	Dual energy X-ray absorption for osteoporosis screening – female only	Women 65 years and older or younger women with increased fracture risk.
	Evaluation for BRCA testing and BRCA lab screening – female only	Screening typically offered to women 18+ yrs. who have family members with breast, ovarian, tubal or peritoneal cancer and who have been screened with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes. Family history factors associated with increased likelihood of potentially harmful BRCA mutations include breast cancer diagnosis before age 50, bilateral breast cancer, family history of breast and ovarian cancer, presence of breast cancer in > 1 male family member, multiple cases of breast cancer in the family, >1 or more family members with 2 primary types of BRCA-related cancer, and Ashkenazi Jewish ancestry. Several familial risk stratification tools are available to determine the need for in-depth genetic counseling, such as the Ontario Family History Assessment Tool, Manchester Scoring System, Referral Screening Tool, Pedigree Assessment Tool, and FHS-7. Women with positive family history and positive screening results may receive genetic counseling and if indicated after counseling, BRCA testing. This test may NOT be given to women whose family history is not associated with an increased risk of mutation or who don't have screening associated with increased risk for BRCA mutation. The screening and history may need to be documented before BRCA testing would be allowed.
	Latent TB Screening Latent TB Screening	Recommended for adults and children.

NOTES: Preventive services are those performed on a person who:

1. Has not had the preventive screening done before and does not have symptoms or other studies suggesting abnormalities; or
2. Has had screening done within the recommended interval with the findings considered normal; or
3. Has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals.
4. Has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy). The therapeutic service would still be considered a preventive service.

ANY of the above services MAY be appropriate if the patient has signs or symptoms of disease but then the tests are DIAGNOSTIC not PREVENTIVE and the reason for the test must be given.

Notes:

5 Reference

UnitedHealthcare Global

Benefit Summary

Florida - Choice Plus Expatriate Insurance - Plan 1967A Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Expatriate Insurance Choice Plus Plan?

Get more protection with a national network plus international and out-of-network coverage.

This plan is designed for customers who want international coverage for employees who are living and working outside of the United States. For coverage inside the United States, a network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage internationally.** Members receive benefits for all covered services when out of the United States.

> **There's coverage if you need to go out of the network.** U.S. Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% International and in our U.S. network.**

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** or call **1-877-844-0280**, Available 24 hours a day, 7 days a week, 365 days a year.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for International and U.S. Network care

This chart is a simple summary of the costs you may have to pay when you receive care internationally or in the U.S. Network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	**(Your cost before the plan starts to pay)**	**(Your cost share after the deductible)**
International: You have no co-payment.	International: You have no individual deductible.	International: You have no co-insurance.
U.S. Network: $15	U.S. Network: $100	U.S. Network: You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Do not use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Annual Deductible		
What is an annual deductible?		
The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.		
> Your co-pays do not count towards meeting the deductible unless otherwise described within the specific covered health care service.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	International: You do not have to pay a medical deductible. U.S. Network: $100 per year	$300 per year
Medical Deductible - Family	International: You do not have to pay a medical deductible. U.S. Network: $300 per year	$900 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	International: You do not have an out-of-pocket limit. U.S. Network: $500 per year	$1,500 per year
Out-of-Pocket Limit - Family	International: You do not have an out-of-pocket limit. U.S. Network: $1,500 per year	$4,500 per year

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

International Benefits apply to Covered Health Care Services that are received outside the United States, including United States territories.

Network Benefits apply to Covered Health Care Services received in the United States that are provided by a Network Physician or other Network provider.

Out-of-Network Benefits apply to Covered Health Care Services received in the United States that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Acupuncture Services		
Limited to $2,500 per year.	International: You pay nothing. A deductible does not apply. U.S. Network: $15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency Ambulance: Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	You pay nothing, after the U.S. network medical deductible has been met.
Non-Emergency Ambulance: Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Bones or Joints of the Jaw and Facial Region		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Cellular and Gene Therapy		
	The amount you pay is based on where the covered health care service is provided.	
	For U.S. Network Benefits, Prior Authorization is required.	Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Cleft Lip/Cleft Palate Treatment		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Clinical Trials		
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 Certificate of Coverage.	The amount you pay is based on where the covered health care service is provided.	
	For U.S. Network Benefits, Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Culturally-Based Services		
Services provided outside the United States that reflect the medical standards of the country in which the service is provided, but which may otherwise be considered alternative treatments when provided within the United States as described under Culturally-Based Services in the Certificate of Coverage.	International: You pay nothing. A deductible does not apply. U.S. Network: Benefits are not available.	Benefits are not available.
Dental Services - Accident Only		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	You pay nothing, after the U.S. network medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Dental Services - Anesthesia and Hospitalization		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self-Management Items:	International: The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Benefit. U.S. Network and Out-of-Network Benefits: The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
Limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for DME or orthotics that costs more than $1,000.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Emergency Evacuation		
Limited to a per diem of $300 for up to 30 days towards the living expenses incurred by the person(s) accompanying you.	International: You pay nothing. A deductible does not apply. U.S. Network: Benefits are not available. You must notify us as soon as the possibility of emergency evacuation arises. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.	Benefits are not available.
	If you suffer a Sickness or Injury and adequate medical facilities are not available locally in the opinion of the attending Physician or our Medical Director or the Medical Director of our affiliate or authorized vendor under our discretion, we will provide emergency evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. Benefits include arranging and providing for transportation and related medical services (including cost of medical escort) and medical supplies incurred in connection with the emergency evacuation. Transportation of your children (under the age of 18) either to the same location as the Covered Person or to a location where the children can be placed under the care of another guardian or relative.	
Emergency Family Reunion		
Limited to a per diem for living expenses for immediate family members of $300 while the Covered Person is hospitalized up to 30 days. In the event that you are hospitalized for more than 7 days, or in the event of your death, Benefits are available to transport your immediate family members to join you.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply. You must notify us as soon as the possibility of emergency family reunion Benefits arises. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.	Benefits are not available.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Emergency Health Care Services - Outpatient		
	International: You pay nothing. A deductible does not apply. U.S. Network: $200 co-pay per visit. A deductible does not apply.	$200 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Enteral Formulas		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Gender Dysphoria		
	International: The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Benefit. U.S. Network and Out-of-Network Benefits: The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.	
	For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment. Visit limits do not apply to Autism Spectrum Disorder.	International: You pay nothing. A deductible does not apply. U.S. Network: $15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient services.
Hearing Aids		
Limited to $5,000 every year. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Home Health Care		
Limited to 120 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive U.S. Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.
Major Diagnostic and Imaging - Outpatient		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Medical Repatriation		
Benefits include Repatriation of Children (under age 18) and adult family members.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply. You must notify us to obtain Benefits for medical repatriation. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.	Benefits are not available.
	After you receive initial treatment and stabilization for a Sickness or Injury, if the attending Physician and our Medical Director or the Medical Director of our affiliate or authorized vendor under our direction determine that it is appropriate to facilitate your recovery, we will transport you back to your permanent place of residence for further medical treatment or to recover. The timing and method of transportation will be determined solely by us and will be suitable to accommodate your medical needs. Covered Services include arranging and providing for transportation and related medical services (including medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.	
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	International: You pay nothing. A deductible does not apply. U.S. Network: $15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Ostomy Supplies		
Limited to $2,500 per year.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient Prescription Drugs		
For U.S. Network and Out-of-Network Benefits are provided as described in your Outpatient Prescription Drug Rider.	International: You pay nothing. A deductible does not apply. U.S. Network: Benefits are not available.	Benefits are not available.
Osteoporosis Treatment		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit:	International: You pay nothing for a primary care physician office visit. A deductible does not apply. U.S. Network: $15 co-pay per visit for a primary care physician office visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit:	International: You pay nothing for a specialist office visit. A deductible does not apply. U.S. Network: $30 co-pay per visit for a specialist office visit. A deductible does not apply.	
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met, except for Child Health Supervision Services. No Deductible applies.
Certain preventive care services are provided with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of Manipulative Treatments. Visit limits do not apply to Autism Spectrum Disorder.	International: You pay nothing. A deductible does not apply. U.S. Network: $15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Repatriation of Remains		
Benefits include Return of Children (under age 18) and adult family members. In the event of your death, we or our affiliate or authorized vendor will render assistance and provide for the return of your mortal remains to your permanent place of residence.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply. You must notify us to obtain Benefits for repatriation of remains. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.	Benefits are not available.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 120 days per year.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Surgery - Outpatient		
	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Temporomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required for Inpatient Stay.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
	The amount you pay is based on where the covered health care service is provided.	
	For International and U.S. Network Benefits, Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	International: You pay nothing. A deductible does not apply. U.S. Network: $50 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Vision Exams		
For U.S. Benefits find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 12 months.	International: You pay nothing. A deductible does not apply. U.S. Network: $15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Wigs		
Limited to a maximum reimbursement of $600 every 24 months.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

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Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

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We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

UnitedHealthcare Global

Addendum to the Medical Benefit Summary

Florida–Choice Plus
Expatriate Insurance

These Benefits are available to you in addition to the standard benefits presented on the Benefit Summary. The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Infertility Services		
Unlimited per Covered Person per lifetime.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing, after the medical deductible has been met. For U.S. Network Benefits, Prior Authorization is required.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

If your coverage includes this benefit, the language "Infertility Treatment" listed in the exclusions section on the Benefit Summary would not apply.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage. **The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.**

UnitedHealthcare® Global

Benefit Summary

Outpatient Prescription Drug Products

Florida Plan 1973A

Standard Drugs: 10/25/60

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on **myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - U.S. Network and Out-of-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - U.S. Network	
Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

Out-of-Pocket Limit does not apply to Out-of-Network Charges and Coupons.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

UnitedHealthcare Insurance Company

Tier Level	Up to 31-day supply		Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	**Retail Out-of-Network Pharmacy**	***Mail Order Network Pharmacy****
Tier 1 Prescription Drug Products	**$10**	**$10**	**$25**
Tier 2 Prescription Drug Products	**$25**	**$25**	**$62.50**
Tier 3 Prescription Drug Products	**$60**	**$60**	**$150**

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

** You will be charged a retail Co-payment and/or Co-insurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

For members that need to take their prescription drugs with them outside the United States, up to 365 day supply may be obtained with a prescription from a Network provider. Certain limitations may apply, such as controlled narcotics or drugs with a limited shelf-life.

Other Important Information about your Outpatient Prescription Drug Benefits

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-network Pharmacy's Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

Certain Preventive Care Medications may be covered. You can get more information by contacting us at myuhc.com® or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy supply limits apply. Please contact us at myuhc.com® or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

PHARMACY EXCLUSIONS

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply to U.S. Network and Out-of-Network Benefits.

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used for cosmetic purposes.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for tobacco cessation.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. An exception to this exclusion may apply for coverage as provided in your Certificate for Enteral Formulas in Section 1 of the COC.

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注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jiik'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jiik'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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UnitedHealthcare Global

Addendum to the Outpatient Prescription Drug Benefit Summary

Florida-Network and Non-Network
Expatriate Insurance

These Benefits are available to you in addition to the standard benefits presented on the Benefit Summary. The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.

Covered Health Care Services	International, U.S. Network and Out-of-Network Benefits
Infertility Maximum Policy Benefit	
The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.	Unlimited for Prescription Drug Products for Infertility per Covered Person.

If your coverage includes this benefit, the language "Prescription Drugs when prescribed to treat infertility" listed in the exclusions on the Outpatient Prescription Drug Benefit Summary would not apply.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail. **The Benefits shown here may change the exclusions indicated on your Benefit Summary.**

UnitedHealthcare

Options PPO/covered dental services

dental plan

Custom GS119

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Policy Year Deductible	$50	$50	$0	$0
Family Annual Policy Year Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	$2000 per person per Policy Year	$2000 per person per Policy Year	$2,000 per person per lifetime	

New enrollee's waiting period:	None
Annual deductible applies to preventive and diagnostic services	No (In Network) No (Out Network)
Annual deductible applies to orthodontic services	No
Orthodontic eligibility requirement	Children Only (Maximum covered age: 19)

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Plan Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.
BASIC SERVICES			
Restorations (Amalgam or Anterior Composite)*	80%	80%	Multiple restorations on one surface will be treated as a single filling.
Emergency Treatment / General Services	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	80%	80%	
Periodontics	80%	80%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns*	80%	80%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	80%	80%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	80%	80%	Once per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Course of treatment is typically 24 months, with the initial payment at banding of 20% and remaining payment spread over the course of the treatment

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

The Prenatal Dental Care and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

General Limitations

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Panorex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

BITEWING RADIOGRAPHS Limited to 1 series of films per Plan Year

EXTRAORAL RADIOGRAPHS Limited to 2 films per Plan Year

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation

RESTORATIONS Multiple restorations on 1 surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribe to control habitual grinding.

FULL MOUTH DEBRIDMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only when clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

General Exclusions

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
13. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the policy for 12 continuous months.
14. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
15. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
16. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
17. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
18. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
19. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
20. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
21. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
22. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia
24. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
25. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
26. Occlusal guard used as safety items or to affect performance primarily in sports-related activities
27. Dental 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.
28. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

UnitedHealthcare Global

Vision Benefit Summary Brochure

Plan B

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating[1] and the frame, or contact lenses in lieu of eye glasses.

Copays for in-network services			
	Exam	$10.00	
	Materials	$25.00	
Benefit frequency			
	Comprehensive Exam	Every 12 months	
	Spectacle Lenses	Every 12 months	
	Frames	Every 24 months	
	Contact Lenses in Lieu of Eye Glasses	Every 12 months	
Frame benefit			
	Network Provider	$130.00 retail frame allowance	
Lens options			
	Standard scratch-resistant coating, tints, ultraviolet coating, polycarbonate, as well as standard and deluxe progressive lenses are covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)		
Contact lens benefit			
	Covered-in-full elective contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full. If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider. **All other elective contact lenses** A $125.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection. Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. **Necessary contact lenses**[3] Covered in full.		
Out-of-network reimbursements		**U.S. Non-Network Benefits**	**International Benefits***
	Exam	$40.00	Up to $80.00
	Frames	$45.00	Up to $110.00
	Single Vision Lenses	$40.00	Up to $60.00
	Bifocal Lenses	$60.00	Up to $80.00
	Trifocal Lenses	$80.00	Up to $115.00
	Lenticular Lenses	$80.00	Up to $130.00
	Elective Contacts in Lieu of Eye Glasses[2]	$105.00	Up to $150.00
	Necessary Contacts in Lieu of Eye Glasses[3]	$210.00	Up to $210.00
Laser vision benefit			
	UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik*Plus* locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.		

[1] On all orders processed through a company owned and contracted Lab network.

[2] The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

[3] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

*For International Benefits only.

ImportanttoRemember:

- Benefit frequency based on last date of service.
- Your $125.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30.00, you will have $95.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- Medically necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming how much of a reimbursement you can expect to receive before you purchase such contacts.
- Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: Global Insurance Service Center, P.O. Box 740111, Atlanta, GA 30374-0111
- UnitedHealthcare Vision offers an Additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy'sTable of Benefits.

UnitedHealthcare Global Expatriate Insurance Claim Form

Return this form with a copy of the bill(s) or receipt(s) online, via mobile app, fax or mail.

Claim Type(s): ○ Medical ○ Dental ○ Vision ○ Pharmacy/Rx

Online	Mobile	Fax	Mail
www.myuhc.com	Download the Health4Me mobile app	+1-877-370-4150 +1-813-870-0796	UnitedHealthcare Global PO Box 740111 Atlanta, GA 30374-0111

Please complete all sections of this claim form.

Claims may be delayed if all sections of this form are not completed. However, this does not guarantee that additional information will not be requested from you to process the claim. You will be notified should additional information be required.

In order to be considered for payment:

International: Filing deadline is 365 days from the date of service.

U.S.: Please refer to your Certificate of Coverage document in www.myuhc.com. If you receive services from a U.S. in-network provider with reimbursement paid directly to the provider, filing deadine is subject to the provider's filing limit.

Please complete a new and separate claim form for:

- Each patient
- Each currency type
- Each inpatient hospital stay
- Each different health care provider (unless multiple invoices with provider information are attached)

Questions? Call Customer Care: +1-877-844-0280 OR **+1-763-274-7362**
UnitedHealthcare Global will accept calls from a relay service for the hearing impaired.

Section 1 – Patient Information

Member ID ☐☐☐☐☐☐☐☐☐ Group Number ☐☐☐☐☐☐☐

Name (Last, First, MI) _____ Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Gender: ○ Male ○ Female

Relationship to Subscriber/Policyholder: ○ Subscriber/Policyholder ○ Spouse/Partner ○ Child ○ Other Dependent

Phone Number _____ Email Address _____

Street _____ Town/City _____

Region/State _____ Country _____ Postal Code _____

Is the patient covered under another insurance health plan? ○ Yes ○ No If Yes: Name address and phone number of other insurance carrier:

_____

Section 2 – Member Reimbursement Options

(Visit **www.myuhc.com** to verify and securely update your banking and currency preference.)

Note: If no selection is made, reimbursement will be via a U.S. dollar check.

○ Use previously provided banking details* ○ Payment by check ○ Electronic funds transfer payment

○ One time reimbursement request (policy holder and dependents 18 years of age older)

*Please check current payment preference on file prior to selection

Bank Name _____ Account Name/Payee _____

Bank Branch Address _____

Local ID or Passport (as applicable) _____ SWIFT/BIC Code _____ IBAN _____

Beneficiary Bank Routing/Sort Code _____ Account Number _____

Would you like to keep the banking details above on file for future reimbursements? (This option is only available to policy holders.) ○ Yes ○ No

Section 3 – Claim Information

Provider/Facility Name _____

Provider/Facility Full Address _____

Provider Phone Number _____ Email Address _____

Where did the treatment take place? City _____ Country _____

Type of Treatment	Diagnosis/Description of Illness or Accident	Date of Service (mm/dd/yy)	Amount Billed	Currency

Are the services provided related to an accident? ○ Yes ○ No

Type of Accident ○ Work ○ Auto ○ Other _____ Date of Accident (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

I authorize my physician to release medical information and records necessary to process this claim.

Signature _____ Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Patient Signature (or Legal Representative)

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature _____

Member/Legal Guardian
Signature of Minor Member or Member's Representative

Print Name _____

Relationship to Member _____

Date ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Please maintain a copy of this document for your records.

UnitedHealthcare® Global

Contact us:

When you need help, our multilingual Customer Care Center is here to support you.

PHONE:

Outside the U.S. or Canada:

Call the Direct Access Number for the country from which you are calling. Visit **https://www.business.att.com/bt/access.jsp** for a list of direct access codes by country. At the prompt, dial **+1.877.844.0280.**

If your country isn't listed, call **+1.763.274.7362.**

In the U.S. or Canada:

Toll-free **+1.877.844.0280**

EMAIL:

To send emails securely to our team:
Log onto myuhc.com, select > Message Center

Alternatively, for general queries, email us at:
expatinsurance_memberservices@uhcglobal.com
Note: You can also chat with customer services at any time once logged onto myuhc.com.

2/20 MBR-C-8951

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