Welcome to your global health benefits.

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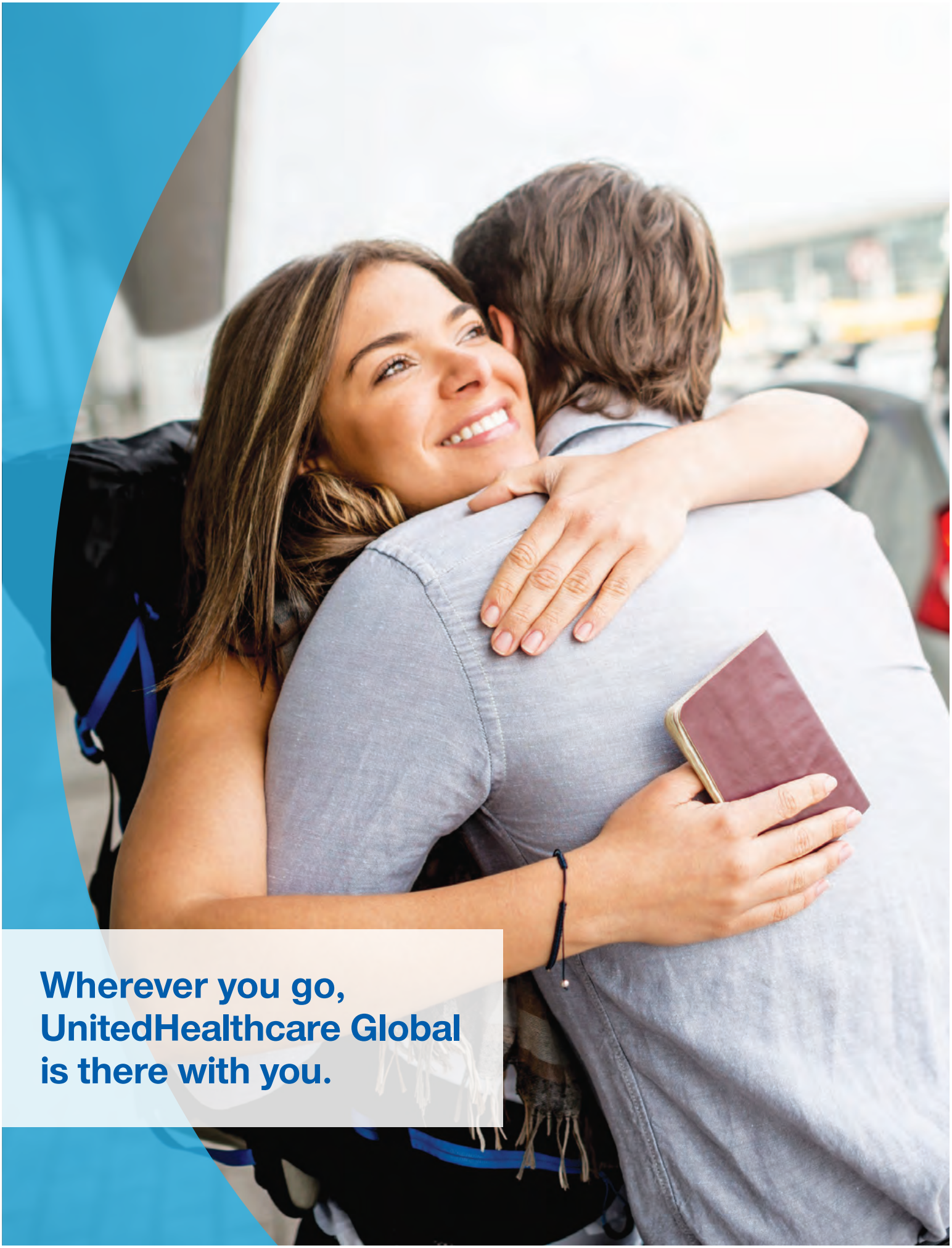
UnitedHealthcare® Global



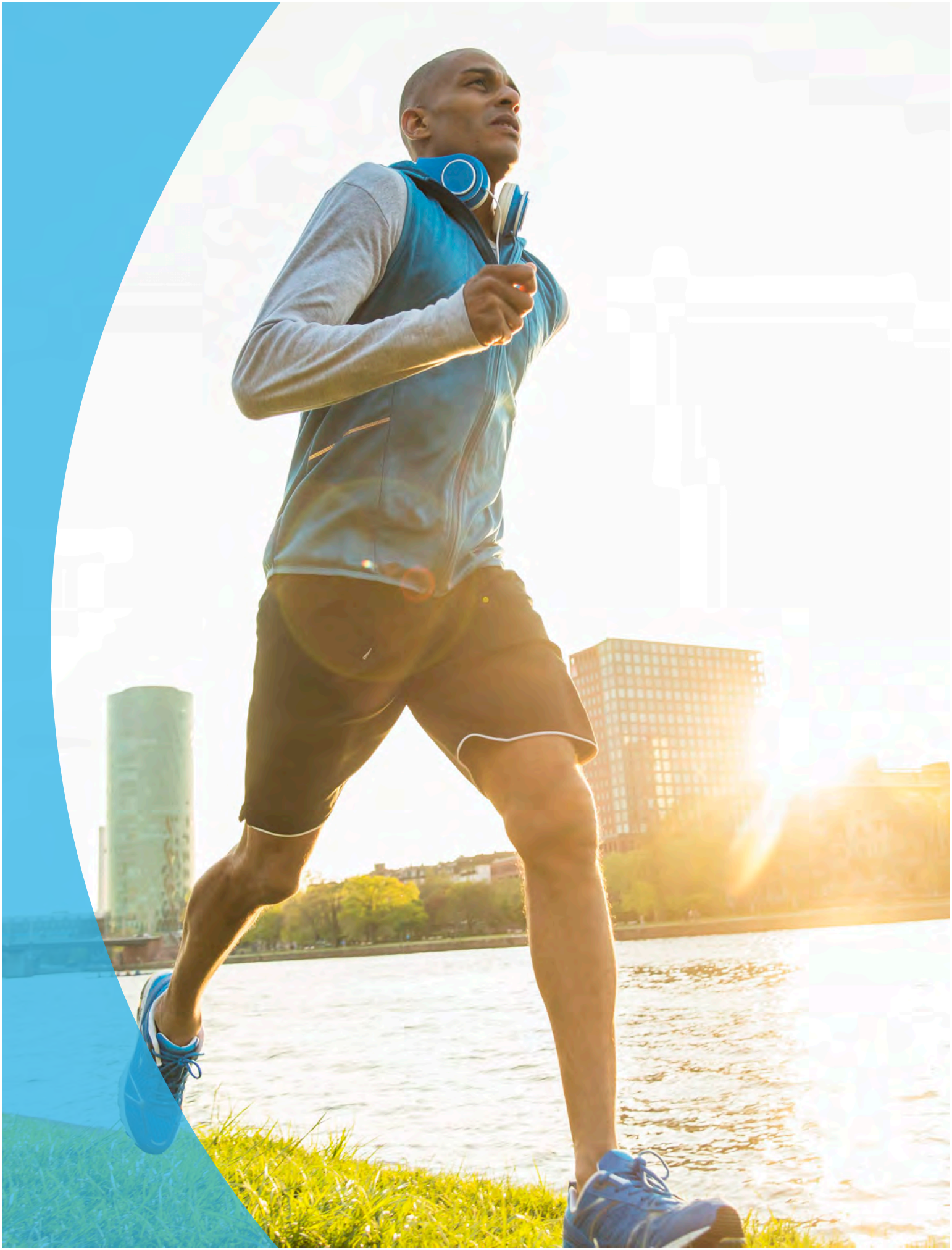
Wherever you go, UnitedHealthcare Global is there with you.

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:

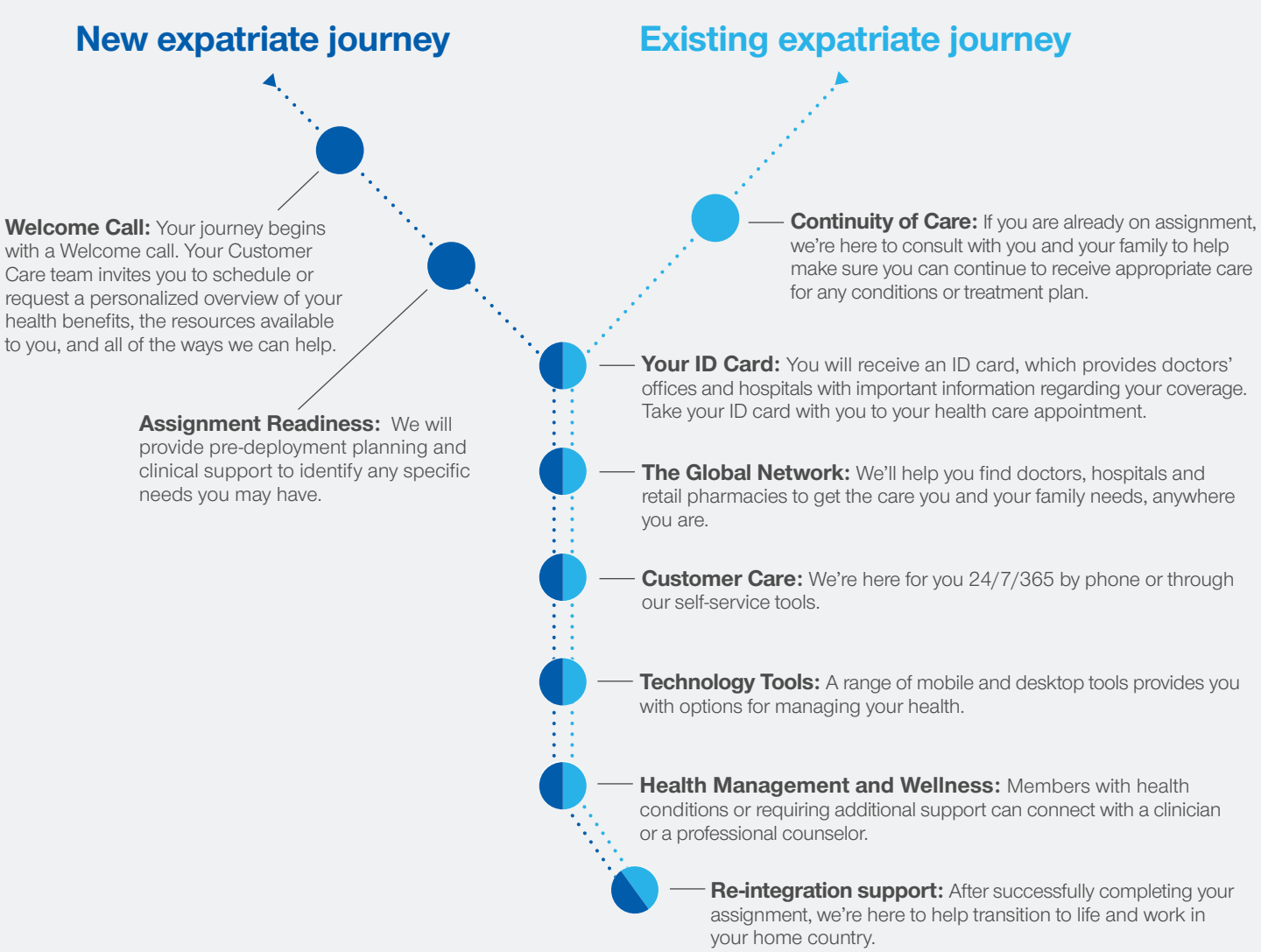


1 Get Started

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.



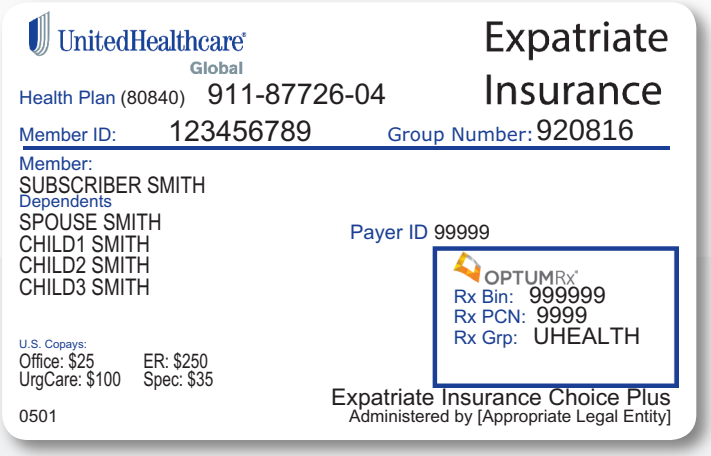
Your medical ID card, one website, one number to call

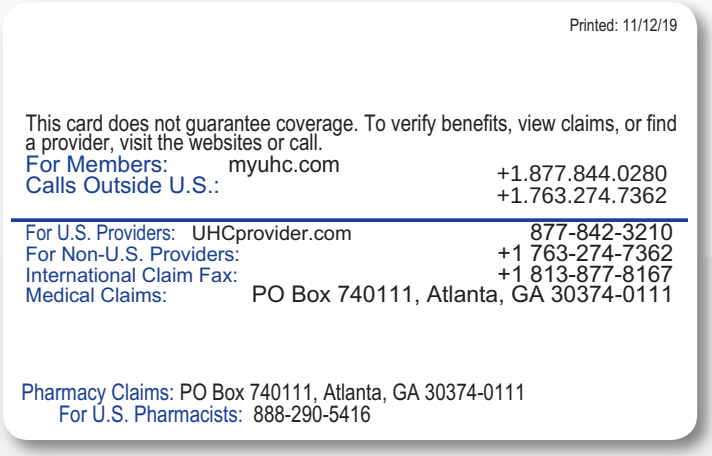
Review your medical ID card

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

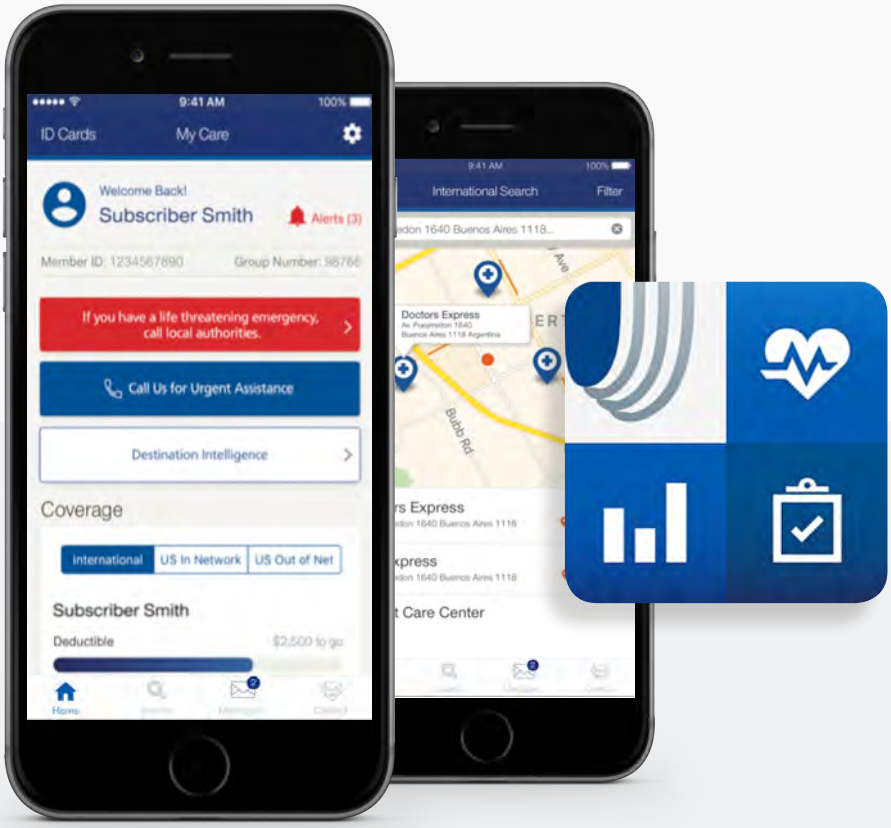
Download the Health4Me® mobile app

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:

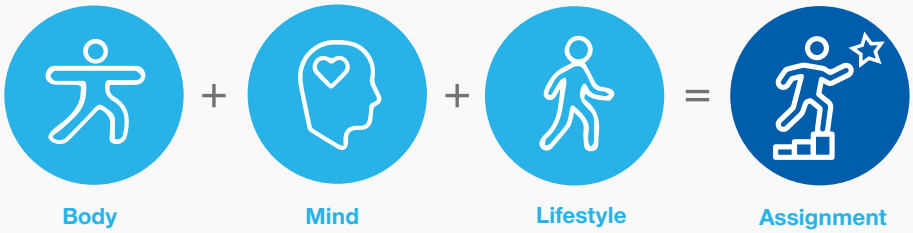
- **Find a doctor, hospital or clinic nearby**
- **Identify providers who accept direct payments from UnitedHealthcare Global**
- **View recent medical and security alerts globally or by country**
- **Subscribe to receive future medical and security alerts for up to 10 countries, including your current 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**

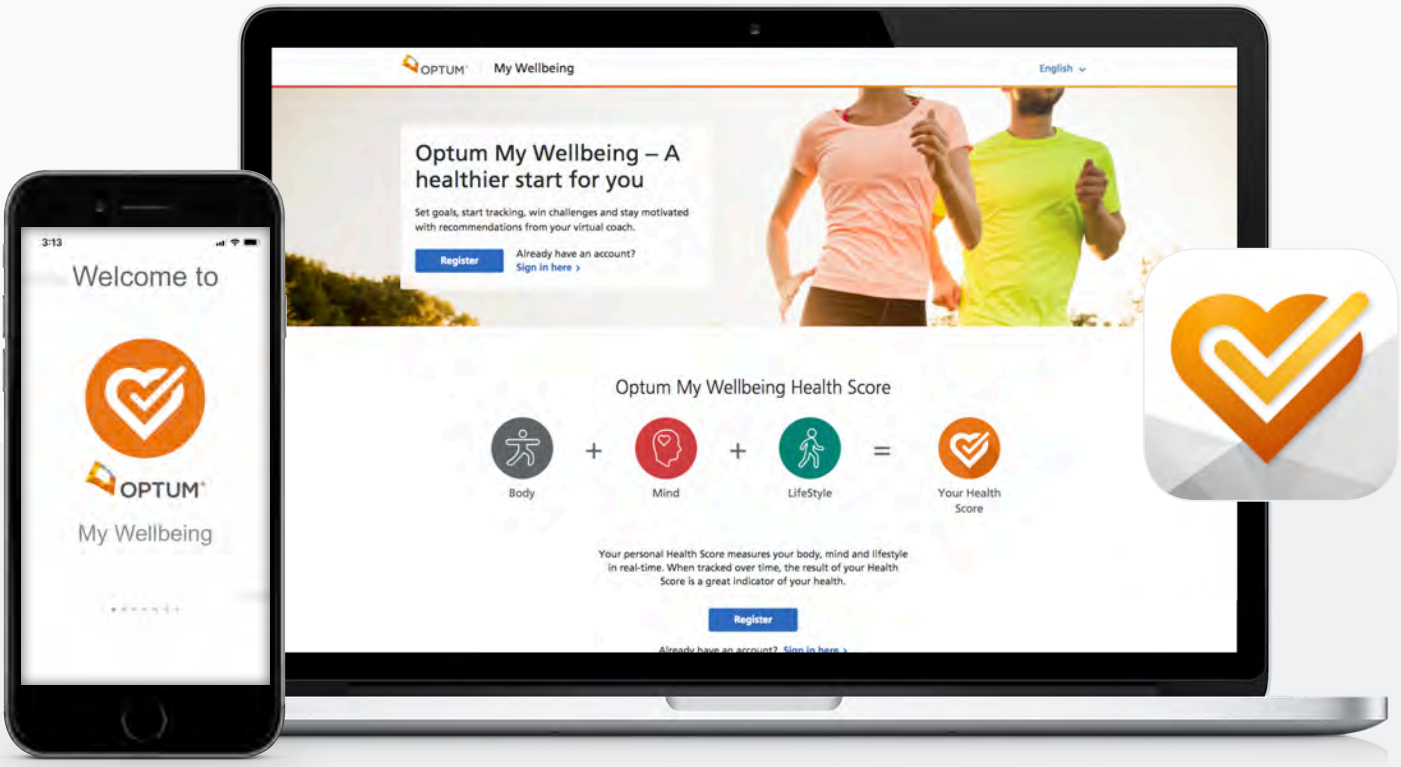


My Wellbeing

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

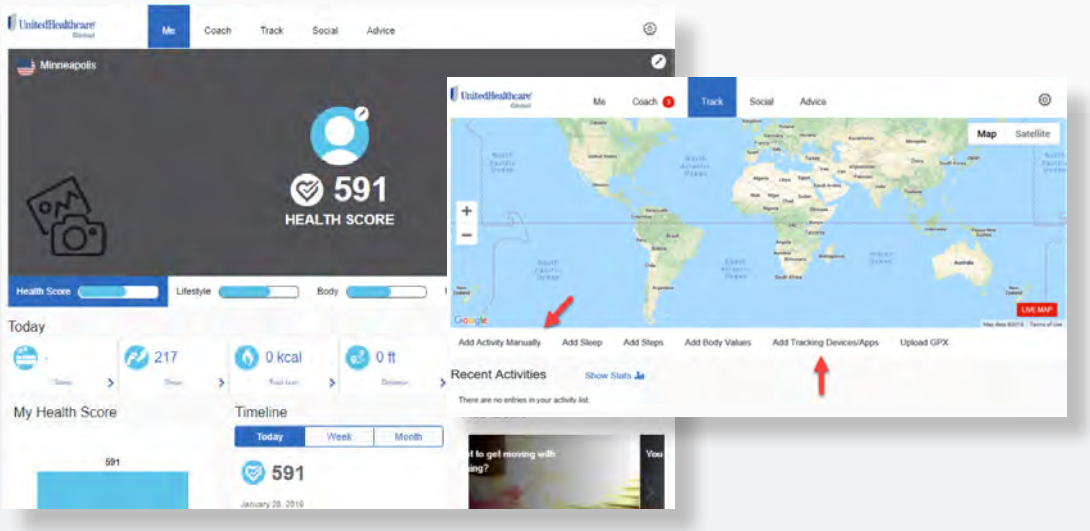
- Get inspired and focused with online communities
- Receive timely coach check-ins and reminders that can help you set goals and stay inspired
- Support available in 12 languages

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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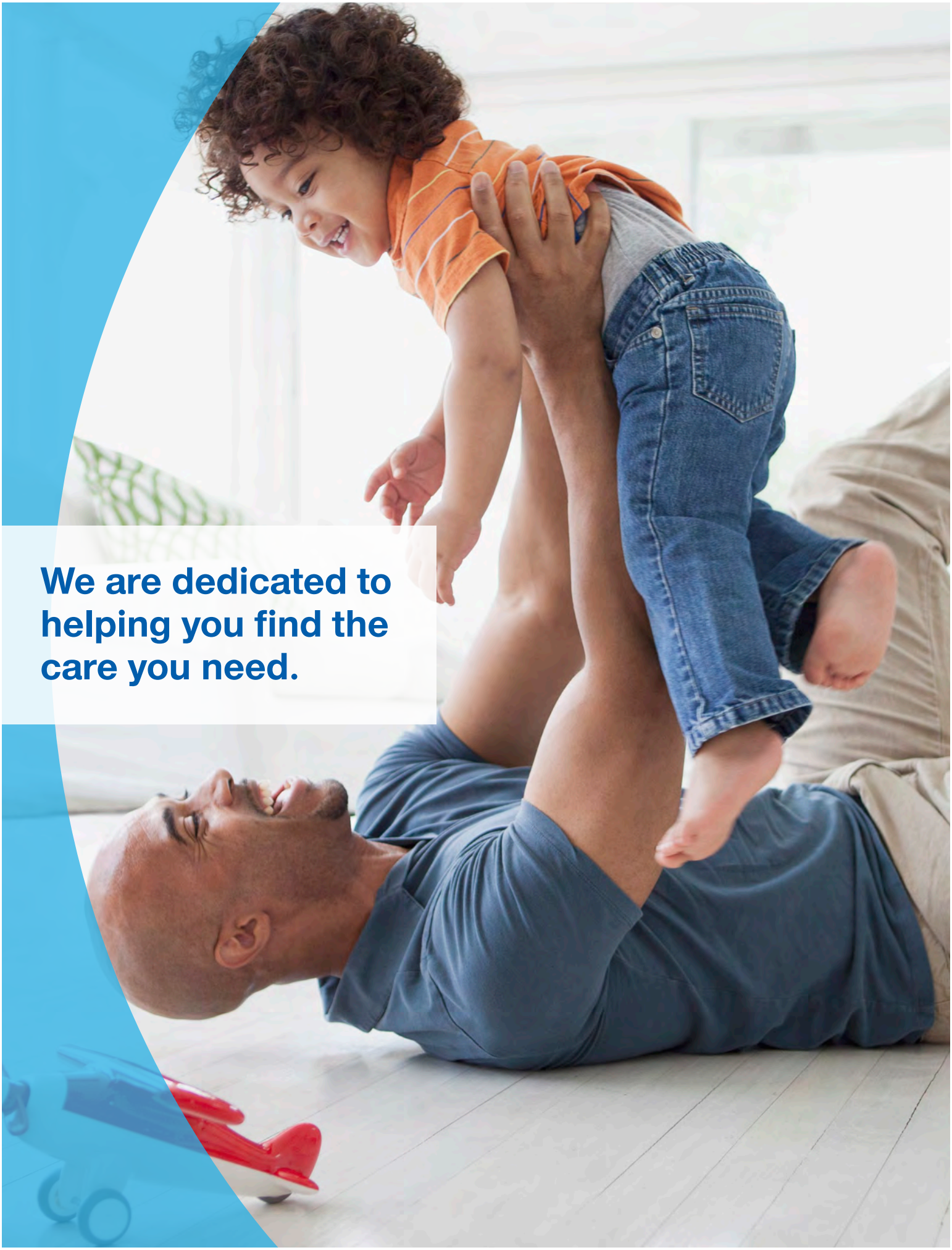


We are dedicated to helping you find the care you need.

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.

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:

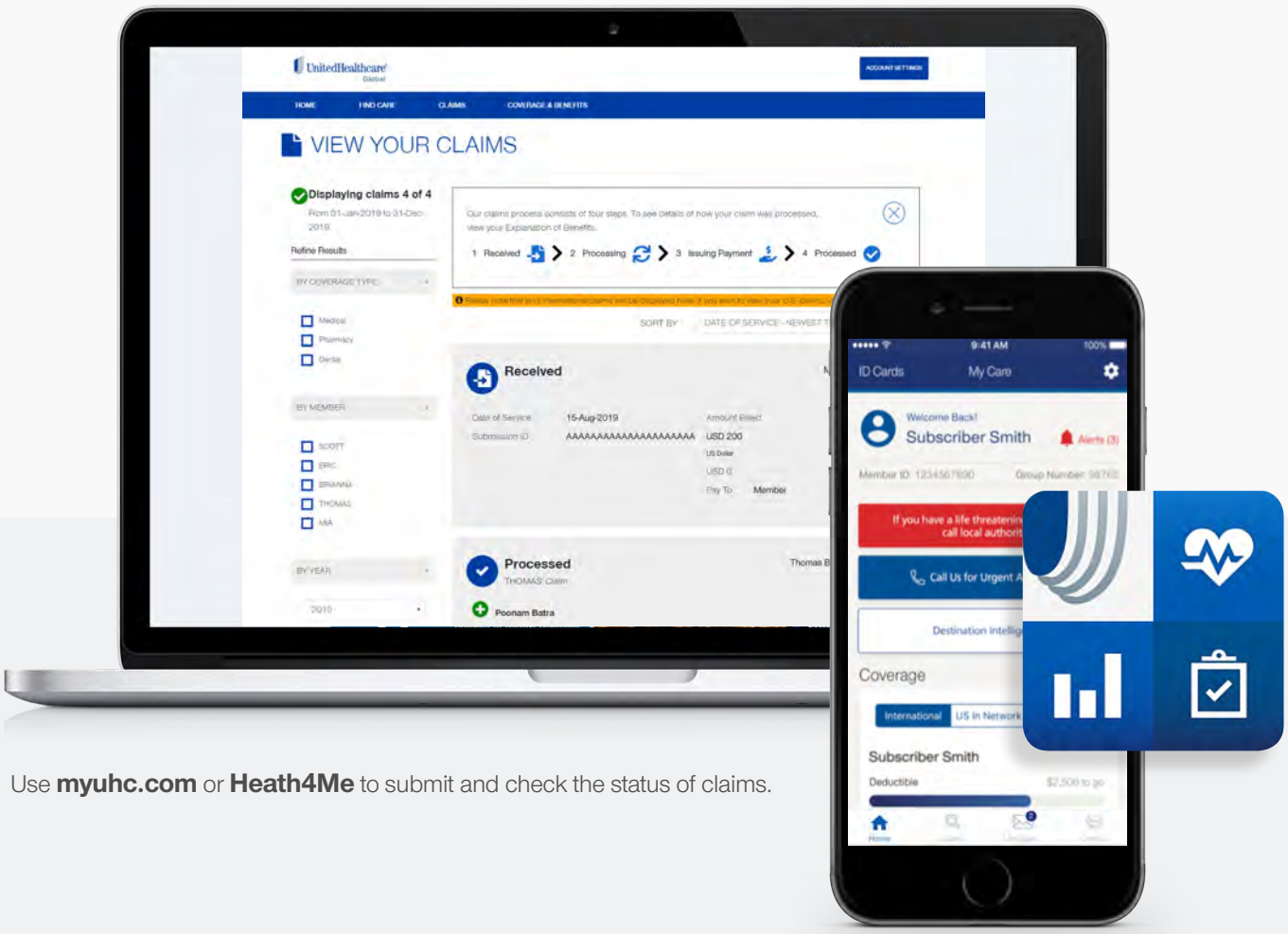
Outside the U.S. or Canada:
Call the Direct Access Number for the country from which you are calling. Visit **https://www.business.att.com/bt/access.jsp** for a list of direct access codes by country. At the prompt, dial **+1.877.370.4150.**

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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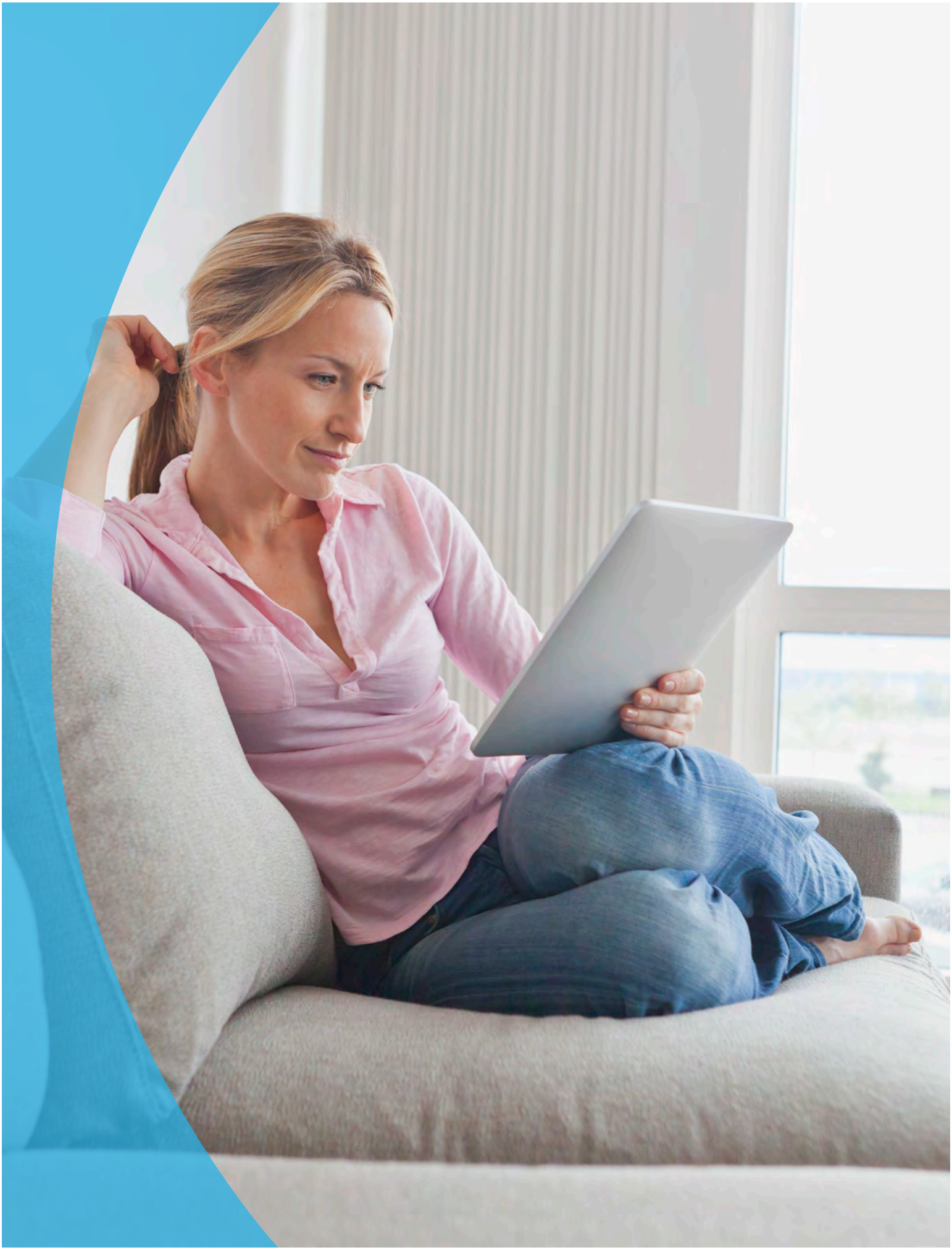


Safe and easy medication management

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.**

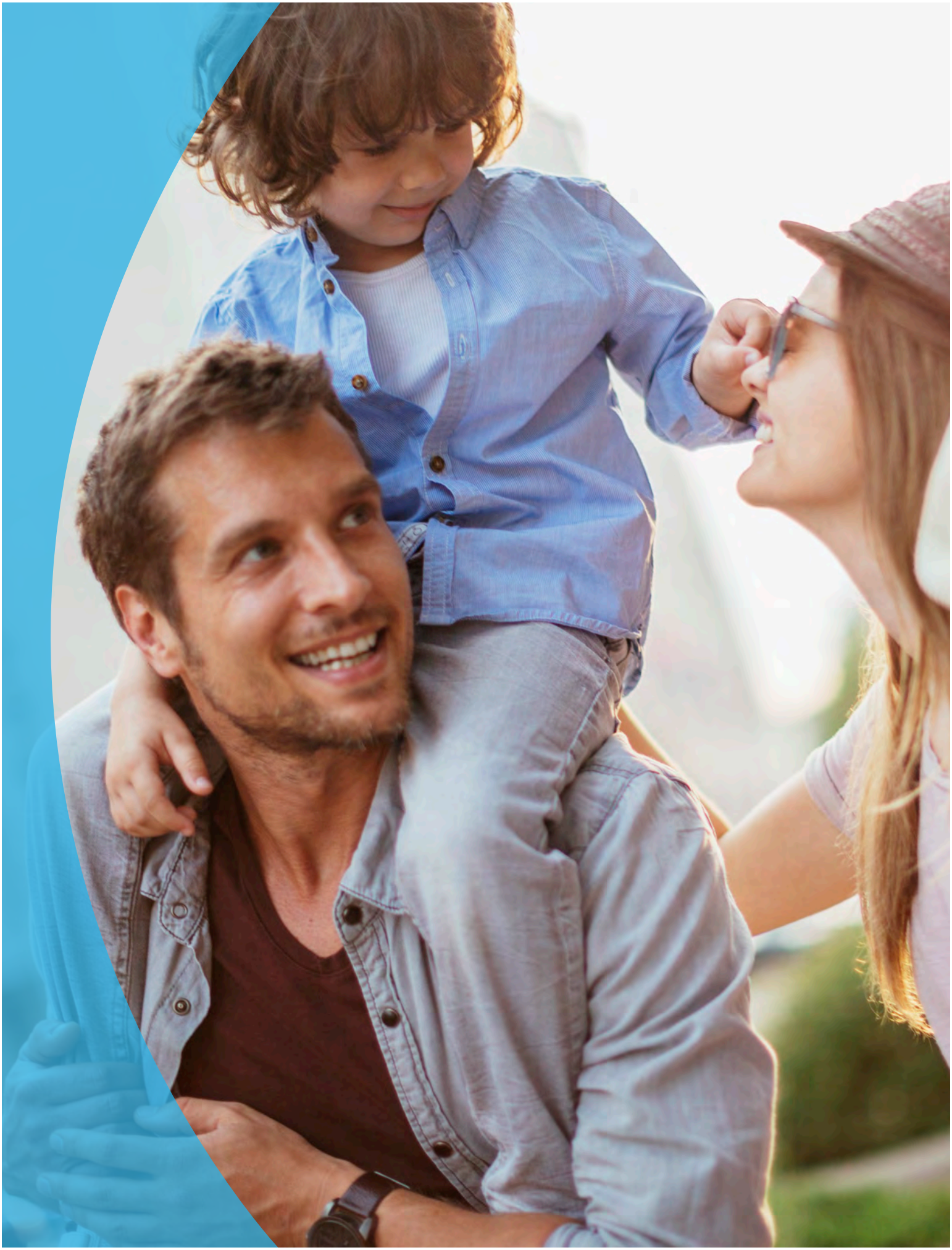
In the U.S. or Canada:
Toll-free **+1.877.844.0280**

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.

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

YOUR BENEFITS

Benefit Summary

California - Choice Plus
Expatriate Insurance - 20/1000/90% Plan 1011A

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

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

PLAN HIGHLIGHTS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	International: No Annual Deductible U.S. Network: $1,000 per year	$2,000 per year
Family Deductible	International: No Annual Deductible U.S. Network: $3,000 per year	$6,000 per year

> Copayments do not accumulate towards the Deductible unless otherwise notated within the specific Benefit category below.

> All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

Out-of-Pocket Maximum (Combined International and U.S. Network)		
Individual Out-of-Pocket Maximum	International: $2,000 per year U.S. Network: $2,000 per year	$3,000 per year
Family Out-of-Pocket Maximum	International: $6,000 per year U.S. Network: $6,000 per year	$9,000 per year

> Copayments, Coinsurance and Deductibles Including Pharmacy accumulate towards the Out-of-Pocket Maximum.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents 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.

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Item#	Rev. Date	
400-7127	0316	Expatriate Insurance/Sep/Emb/23024/2011

UnitedHealthcare Insurance Company

Prescription Drug Benefits

U.S. Prescription drug benefits are shown under separate cover.

Benefit Plan Coinsurance - The Amount We Pay

	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid.

> When Benefit limits apply, the limit refers to any combination of International, U.S. Network and Non-Network Benefits unless specifically stated in the Benefit category.

MOST COMMONLY USED BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Physician's Office Services		
Primary Physician Office Visit	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $20 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $40 Copayment per visit.	70% after Deductible has been met.

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	International: 100%, Copayments and Deductibles do not apply. U.S. Network: 100%, Copayments and Deductibles do not apply.	70% after Deductible has been met.
Specialist Physician Office Visit	International: 100%, Copayments and Deductibles do not apply. U.S. Network: 100%, Copayments and Deductibles do not apply.	
Lab, X-Ray or other preventive tests	International: 100%, Copayments and Deductibles do not apply. U.S. Network: 100%, Copayments and Deductibles do not apply.	
The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.		
Urgent Care Center Services		
	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $50 Copayment per visit.	70% after Deductible has been met.
> In addition to the Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
Emergency Health Services - Outpatient		
	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $200 Copayment per visit.	100% after you pay a $200 Copayment per visit. *Notification is required if confined in a non-Network Hospital.*
Hospital - Inpatient Stay		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*

ADDITIONAL CORE BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Acupuncture		
Benefits are limited as follows: $2,500 in Eligible Expenses per year	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $20 Copayment per visit.	70% after Deductible has been met.
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	90% after U.S. Network Deductible has been met.
Air Ambulance	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met. *For U.S. Network Benefits, Prior Authorization is required for non-Emergency Ambulance.*	90% after U.S. Network Deductible has been met. *Prior Authorization is required for non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Dental Services - Accident Only		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met. *For U.S. Network Benefits, Prior Authorization is required.*	90% after U.S. Network Deductible has been met. *Prior Authorization is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items	International: For diabetes equipment, Benefits will be the same as those stated under Durable Medical Equipment. For diabetes supplies the Benefit is 90% of Eligible Expenses and Benefits are not subject to payment of the Annual Deductible. Coinsurance applies to the Out-of-Pocket Maximum. U.S. Network and Non-Network: Benefit category does not apply. See Diabetes Treatment under state mandate section.	

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Durable Medical Equipment		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Durable Medical Equipment in excess of $1,000.*
Habilitative Services		
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.	
Hearing Aids		
Benefits are limited as follows: $5,000 per year and are further limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 120 visits per year	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Hospice Care		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Inpatient Stay.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	International: 100% Deductible does not apply. U.S. Network: 100% Deductible does not apply.	70% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	International: 100% Deductible does not apply. U.S. Network: 100% Deductible does not apply.	70% after Deductible has been met. *Prior Authorization is required for sleep studies.*

ADDITIONAL CORE BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Ostomy Supplies		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.
Pregnancy - Maternity Services		
For U.S Network and Non-Network Benefits: We pay for Covered Health Services incurred if you participate in the Expanded Alpha Feto Protein (AFP) program, a statewide prenatal testing program administered by the State Department of Health Services.	International: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	U.S. Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy.	U.S. Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary, 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 Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Prosthetic Devices		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Prosthetic Devices in excess of $1,000.*

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of Manipulative Treatments 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $20 Copayment per visit.	70% after Deductible has been met.
		Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 120 days per year	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required.
Surgery - Outpatient		
	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required for certain services.
Temporomandibular Joint Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Benefit Summary.	
		Prior Authorization is required for Inpatient Stay.

ADDITIONAL CORE BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for certain services.*
Transplantation Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For U.S. Network Benefits, services must be received at a Designated Facility. *For International and U.S. Network Benefits, Prior Authorization is required.*	Non-Network Benefits are not available.
Vision Examinations		
Benefits are limited as follows: 1 exam every 2 years	International: 100% Deductible does not apply. U.S. Network: 100% after you pay a $20 Copayment per visit.	70% after Deductible has been met.
Wigs		
Benefits are limited as follows: $5,000 every 24 months	International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Breast Cancer Services		
	International: Benefit category does not apply to International Benefits. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For U.S. Network Benefits, Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. International: To be a qualifying clinical trial for services outside the United States, a clinical trial must meet all of the criteria as described under Clinical Trials in the Expatriate Insurance Rider.	
	For U.S. Network Benefits, Prior Authorization is required.	*Prior Authorization is required.*
Dental Anesthesia Services		
For U.S Network and Non-Network Benefits: Services are limited to Covered Persons who are one of the following: A child under seven years of age. A person who is developmentally disabled, regardless of age. A person whose health is compromised and for whom general anesthesia is required, regardless of age.	International: Benefit category does not apply to International Benefits. U.S. Network: 90% after Deductible has been met.	70% after Deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required.	*Prior Authorization is required.*
Diabetes Treatment		
For U.S Network and Non-Network Benefits: Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.	International: Benefit category does not apply to International Benefits. See Diabetes Self Management Items U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. Benefits for diabetes supplies will be the same as those stated in the Outpatient Prescription Drug Rider.	
	For U.S. Network Benefits, Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Mastectomy Services		
	International: Benefit category does not apply to International Benefits. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For U.S. Network Benefits, Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Mental Health Services		
	Inpatient: International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	Inpatient: 70% after Deductible has been met.
	Outpatient: International: 90% Deductible does not apply. U.S. Network: 100% after you pay a $20 Copayment per visit.	Outpatient: 70% after Deductible has been met.
		Prior Authorization is required for certain services.
Off-Label Drug Use and Experimental or Investigational Services		
	International: Benefit category does not apply to International Benefits. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Osteoporosis Services		
	International: Benefit category does not apply to International Benefits. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Phenylketonuria (PKU) Treatment		
	International: Benefit category does not apply to International Benefits. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For U.S. Network Benefits, Prior Authorization is required.	*Prior Authorization is required.*

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Prosthetic Devices - Laryngectomy		
	International: Benefit category does not apply to International Benefits. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For U.S. Network Benefits, Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Substance Use Disorder Services		
	Inpatient: International: 90% Deductible does not apply. U.S. Network: 90% after Deductible has been met.	Inpatient: 70% after Deductible has been met.
	Outpatient: International: 90% Deductible does not apply. U.S. Network: 100% after you pay a $20 Copayment per visit.	Outpatient: 70% after Deductible has been met.
		Prior Authorization is required for certain services.
Telehealth Services		
	International: Benefit category does not apply to International Benefits. U.S. Network and Non-Network: Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	

ADDITIONAL INTERNATIONAL BENEFITS

Types of Coverage	International Benefits
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 Expatriate Insurance Rider.	90% Deductible does not apply.
Emergency Evacuation	
A per-diem of $300 for up to 30 days to cover living expenses for the person(s) accompanying the Covered Person at the evacuation destination.	100% Deductible does not apply. If you suffer a Sickness or Injury and adequate medical facilities are not available locally in the opinion of the attending Physician 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. *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.*
Emergency Family Reunion	
A per diem for living expenses for immediate family members of $300 while the Covered Person is hospitalized up to 30 days.	100% Deductible does not apply. 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. *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.*
Medical Repatriation	
Benefits include Repatriation of Children (under age 18).	100% Deductible does not apply. 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. *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.*
Outpatient Prescription Drugs	
	90% Deductible does not apply.

Types of Coverage	International Benefits
Repatriation of Remains	
Benefits include Return of Children (under age 18).	100% Deductible does not apply. 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. *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.*

EXCLUSIONS

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. These exclusions apply to the International, U.S. Network and Non-Network Benefit unless otherwise indicated below.

Alternative Treatments

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

Dental

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

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC and speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for use outside of a healthcare setting that are filled by a prescription order or refill (i.e. a supply of prescription drug products for home/personal use). This exclusion does not apply if the Policy includes an Outpatient Prescription Drug Rider. (This exclusion does not apply to International Benefits). Self-injectable medications, except those needed to treat diabetes. This exclusion does not apply to medications which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under Section 9: Defined Terms and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the American Hospital Formulary Service's Drug Information; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Shoe orthotics. This exclusion does not apply to shoes for which Benefits are provided as described under Specialized Footwear in Section 1 of the COC. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Arch supports. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.

Medical Supplies

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

- Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC.
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified as mental disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the final two chapters of Part II of the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. These codes are ICD-10-CM diagnostic and statistical codes beginning with the letter R or letter T. Educational/behavioral services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness or Serious Emotional Disturbances in Section 9 of the COC. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

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

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

Enteral feedings, even if the sole source of nutrition, except as described under Phenylkeonuria (PKU) Treatment in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods), except as described under Phenylkeonuria (PKU) Treatment in Section 1 of the COC.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement and as required by California regulation); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Treatment of benign gynecomastia (abnormal breast enlargement in males). This exclusion does not apply to the reconstructive and Medically Necessary treatment of benign gynecomastia for male patients. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Psychosurgery. Gender/sex reassignment surgery is not covered unless the same procedure is allowed in the treatment of another condition, not related to gender identity or gender dysphoria. This exclusion does not permit the denial of coverage if the health care services involved are otherwise available under the Policy, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training. Also, this exclusion does not permit the denial of coverage for health care services available to a Covered Person of one sex due only to the fact that the Covered Person is enrolled as belonging to the other sex or has undergone, or is the process of undergoing, a gender transition. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations; and physical therapy modalities that have general value but show limited or no efficacy in the treatment of TMJ including cold laser, diathermy, thermography, iontophoresis, biofeedback, and TENS. Upper and lower jawbone surgery, except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in Temporomandibular Joint (TMJ) Services under Section 1 of the COC. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under Other Health Education Services for You in the section of the COC titled Our Responsibilities. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under Preventive Care Services in Section 1 of the COC. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

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

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is paid by federal, state or local law or provided through other arrangements. Examples include coverage required by workers' compensation, Defense Base Act (DBA) coverage (for International Benefits), no-fault auto insurance, or similar legislation. This exclusion only applies when you are legally entitled to such other coverage and you are able to receive health services under the other coverage arrangement. Health services provided while you are covered under a separate policy issued through your Enrolling Groups as stipulated by a foreign governmental requirement (for International Benefits only). For U.S. Benefits: Health services while on active military duty when you are on active duty for more than 30 days.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. The exclusion for methadone treatment as maintenance does not apply to Covered Persons during pregnancy and for two months after delivery received on an outpatient basis at a licensed treatment center. Educational/behavioral services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness and Serious Emotional Disturbances in Section 9 of the COC. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

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

Types of Care

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

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when the Covered Person has either of the following: Craniofacial anomalies in which normal or absent ear canals preclude the use of a wearable hearing aid, or Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following: Medically Necessary or not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in the United States or non-war zones outside of the United States. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies theprognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when claims payment and/or coverage is prohibited by applicable law.

UnitedHealthcare®

Addendum to the Medical Benefit Summary

California
Choice Plus

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Gender Dysphoria		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required for certain services.	

This Gender Dysphoria exclusion applies:
Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

This Procedures and Treatments exclusion no longer applies when Gender Dysphoria applies:
Sex transformation operations and related services.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, these documents shall prevail. It is recommended that you review these documents 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. **The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.**

CATGYYYYY16

UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare 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.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other 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.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

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.

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.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल 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

California – 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.

ADDITIONAL BENEFITS

Types of Coverage	International and U.S. Network Benefits	Non-Network Benefits
Vision Materials		
Includes Eyeglass Frames and Eyeglass Lenses or Contact Lenses. Reimbursement is limited to a Combined total of $100 once every 12 months.	International: 100% to a maximum reimbursement of $100. U.S. Network: 100% to a maximum reimbursement of $100.	100% to a maximum reimbursement of $100.

If your coverage includes this benefit, the language “Purchase cost and fitting charge for eye glasses and contact lenses” listed in the **Vision and Hearing** exclusion on the Benefit Summary would not apply.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, these documents shall prevail. It is recommended that you review your these documents 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. **The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.**

CAZGCVZZZ15_2011 Rev. Date: 0816

UnitedHealthcare Global

YOUR BENEFITS

Benefit Summary

Outpatient Prescription Drug

California

20/40/75 Plan 01018A

Your Copayment and/or Coinsurance 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 on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - U.S. Network and Non-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Maximum - U.S. Network and Non-Network

Individual Out-of-Pocket Maximum	See Medical Benefit Summary
Family Out-of-Pocket Maximum	See Medical Benefit Summary

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	U.S. Network	**Non-Network**	**U.S. Network**
Tier 1	**$20**	**30%**	**$50**
Tier 2	**$40**	**30%**	**$100**
Tier 3	**$75**	**30%**	**$187.50**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

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.

Note: If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

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.

CAMRCW01018A15

Item#	**Rev. Date**
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UnitedHealthcare Insurance Company

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Also note that some Prescription Drug Products require that you obtain prior authorization from us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

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 Non-Network Benefit for that Prescription Drug Product.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply to the U.S. Network and Non-Network Benefits.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for Experimental indications and/or dosage regimens that are Experimental, Investigational or Unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered. This exclusion does not apply to vitamins that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) that are required to be covered under the Patient Protection and Affordable Care Act (PPACA).
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
- 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 comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that are Therapeutically Equivalent to an over-the-counter drug or supplement. 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. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of health condition, except as described under Phenylkeonuria (PKU) Treatment in Section 1of the COC.

PHARMACY EXCLUSIONS CONTINUED

- 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 that have not been prescribed by a Specialist Physician.
- A Prescription Drug Product that contains marijuana, including medical marijuana.

Notes:

Notes:

UnitedHealthcare Global Expatriate Insurance Claim Form

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

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

Website:	**Mobile:**	**Address:**	**Fax:**	**Direct Dial Fax:**
Submit Claims online at www.myuhc.com	Submit claims via the Health4Me app on your smartphone	UnitedHealthcare Global PO Box 740111 Atlanta, GA 30374-0111	+1.877.370.4150	+1.813.870.0796

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.

Please complete a new and separate claim form for:
- Each patient • Each currency type • Each inpatient hospital stay
- Each different healthcare 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 # _____ 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:

_____

Reimburse: ○ Member ○ Provider ○ Other If Other selected, please provide name _____

If reimbursement is to provider or other, please provide your signature here _____

Section 2 – Member Reimbursement Options

(In order to save you time, you may access **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

*Please check current payment preference on file prior to selection

Bank Name _____ Account Name/Payee _____

Bank Branch Address _____

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? ○ Yes ○ No

Section 3 – Claim Information

Provider/facility name _____

Provider/facility full address _____

Where did the treatment take place? City _____ Country _____

Section 3 – Claim Information (cont.)

Type of Treatment	Description of Illness	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)

Section 4 – To Be Completed by Treating Physician for Any Services Listed Below

Type of care: ○ Inpatient Admission ○ Outpatient surgery ○ Diagnostic Testing ○ Home Health Care ○ Injectable Medications ○ Radiation Therapy ○ Chemotherapy ○ Outpatient Therapy

Complete Applicable Information Below (Please Print)

Diagnosis _____ Date symptoms first started (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Physical Evaluation _____

Physician's Orders or Prescription _____

Diagnostic Test Results _____

Prior History Treatment _____

Co-morbid Conditions _____

Physician's notes/Comments _____

_____

_____

Physician Name (please print) _____ Medical Profession _____

Phone number (with country code) _____ E-mail _____

Physician's Full Address _____

Country _____

Signature of Treating Physician _____ Date ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

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.**

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Toll-free **+1.877.844.0280**

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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.

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