



Welcome

**Explore the ways your international
benefit plan can help you thrive**

Peter Kiewit Sons', Inc.

UnitedHealthcare Global Customer Support:
+1.877.844.0280

**United
Healthcare
Global**

Thanks for being a member

We're here to help make accessing your international benefit plan easier. Use this guide as a tool to help you better understand your benefits, find care options, manage costs and get more out of your plan—and start experiencing all that your benefits can do for you.

If you do not have computer access, need assistance or have questions after reading this guide, please call the number on your ID card. [Click here](#) for a list of toll-free international access codes. Be prepared to provide the information on your ID card, a description of the situation and a phone number to contact you.

If this is a medical emergency follow the “first call” protocol for the country you are in. [Click here](#) for a complete listing of international emergency contact numbers by country.



Connect with us

Email
myuhc.com
uhcglobal.com



Locate your ID card

An ID card will be sent to you in the mail. Always carry your ID card with you. You can also find your digital ID card on myuhc.com and in the UHC Global app.

Your ID card contains valuable information about your coverage, so it's important to know what everything means. [Click here](#) for a guide on how to read your ID card.

			Expatriate Insurance
Member: SUBSCRIBER SMITH		Group Number: 9999999	
Member ID: 123456789		Customer Name	
Dependents: SPOUSE SMITH CHILD1 SMITH CHILD2 SMITH CHILD3 SMITH		Payer ID: 87726	
U.S. Only: Office: \$25 ER: \$100 UrgCare: \$35 Spec: \$40 Coins 10%		Rx Bin: 610279 Rx PCN: 9999 Rx Grp: UHEALTH	
Ded IND/FAM \$375/\$750 OON: \$1000/\$2000		OOPM IND/FAM \$2500/\$7500 OOPM IND/FAM \$5000/\$13000	
Expatriate Insurance Choice Plus Underwritten by UnitedHealthcare Insurance Company		Expatriate Insurance Choice Plus Underwritten by UnitedHealthcare Insurance Company	

This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.

For Members: myuhc.com +1 877-844-0280
 Calls Outside U.S.: +1 763-274-7362

For U.S. Providers: UHCprovider.com 877-842-3210
 For Non-U.S. Providers: +1 763-274-7362
 International Claim Fax: +1 813-877-8167
 Medical Claims: PO Box 740111, Atlanta, GA 30374-0111

Pharmacy Claims: PO Box 740111, Atlanta, GA 30374-0111
 For U.S. Pharmacists: 888-290-5416

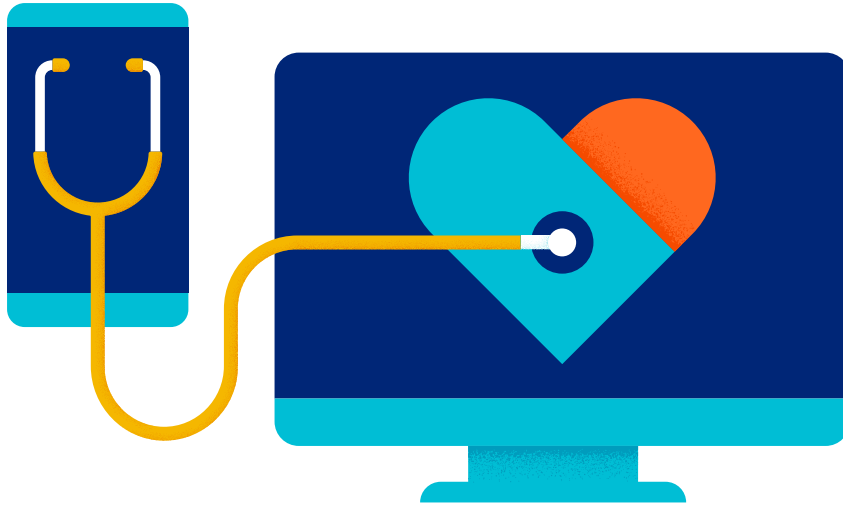
Note that this is a sample ID card image and your own ID card may differ.



Connect with us

Your employer may choose to offer you a welcome call with one of our experienced team members. During the call, they will walk you through your benefits, answer questions and address concerns you might have about your health or the health of qualifying dependents. They will also confirm or collect your email address should we need to connect with you.

If you or your employer chooses to provide us with your email address, you will receive a series of welcome emails filled with tips on how to activate and use your plan.



Activate your myuhc.com[®] account

When it comes to managing your plan, myuhc.com lets you see what's covered, manage costs and so much more. To help everyone get more from their plan, it's important that each member aged 18 and over consider creating their own account.

Use myuhc.com to:

- Find the average cost of care
- See what's covered
- View claim details
- Check your plan balances
- Find network providers

Get started today:

- Go to myuhc.com
- Have your ID card handy and follow the step-by-step instructions

For more assistance on how to connect to your plan, [click here](#).

Download the UnitedHealthcare Global app

The UHC Global app puts your plan at your fingertips. Download it to:

- Find local in-network care
- View and share your ID card with your provider's office
- Easily check your coverage details, submit claims and more





How to read your certificate of coverage and benefits summary

When you understand your benefits, you can make more informed health care decisions. The certificate of coverage (CoC), located on myuhc.com, describes your plan in detail. While long, it can be helpful if you need to know something specific. If you want an easy-to-read summary that lets you quickly review the plan, refer to your benefits summary.

Both documents are designed to help you understand what is and is not covered, as well as your plan's costs, including types of coverage, deductible amounts and out-of-pocket limits. They also contain information on coverage for in-network and out-of-network providers so you know what your costs will be ahead of time and can help you avoid surprise bills.

Learn more about Understanding your Explanation of Benefits statement. Navigate to myuhc.com > Coverage & Benefits > Plan Documents to view your CoC



For additional assistance with the information in your CoC or benefits summary, call the number on your ID card.

Transition of care services

If you are currently undergoing a course of treatment using an out-of-network physician or health care facility in the U.S., you may be eligible to receive transition of care benefits that prevent disruption of your current treatment plans.

You have the option to request extended coverage from your current, out-of-network health care provider at network rates for a limited time due to a specific medical condition until the safe transfer to a network health care professional can be arranged. This transition period is available for specific medical services and for limited periods of time.

If you have questions regarding this transition of care reimbursement policy or would like help finding out if you are eligible for transition of care benefits, call the number on your ID card.



Pharmacy benefits

OptumRx® pharmacy services help make it easier to save on medications and keep track of them, too—whether you're online or on the go.

Visit myuhc.com > Pharmacies & Prescriptions to:

- Find and compare medication costs
- Locate a network pharmacy
- See if your medications have any requirements before filling them

Keep costs in check

Your Prescription Drug List (PDL)—available on myuhc.com—lists the most prescribed medications covered by your plan. Choosing medications in the lower tiers may help you save money. Consider generic medications instead of brand names, which may keep costs down.

Keep in mind that your plan covers prescription medication only. Pharmacy benefits will not apply if your medication is available over-the-counter in the host country.

Fill your prescriptions before you go

You are eligible to receive up to a one-year supply of prescription medication. It's important to talk to your primary care provider (PCP) before you depart to make sure the medications you are on are available in your host country or have a comparable option.

Call the number on your ID card for assistance filling, storing and finding comparable prescriptions. Visit myuhc.com to see drug name translations and get detailed information on medications.

Buying prescriptions abroad

Certain federal regulations prohibit the shipment of prescription medication, so it is best to fill your prescriptions at local retail pharmacies. Call the number on your ID card or visit myuhc.com to locate a retail pharmacy nearby. You can pay for your medication and submit a claim to us for reimbursement.

It is important to know that medication names and strengths can vary from country to country. Call the number on your ID card for help in understanding medication differences.

Dental benefits

Taking care of your teeth and gums is important to your overall health. If you have dental benefits as part of your plan, you can use the services of any dentist or dental specialist around the world.

- To view your dental benefits, visit myuhc.com
- To find a provider, visit myuhc.com or call the number on your ID card
- To receive an estimate for dental services exceeding \$500 and to arrange for direct payment to a provider, call the number on your ID card
- You do not need a referral to see a dental specialist

Vision benefits

If you have vision benefits, a comprehensive eye exam can do more than test your vision. It can also identify symptoms of many health problems, such as diabetes, hypertension, high cholesterol, glaucoma and cataracts.

- To learn about your vision benefits, visit myuhc.com
- To find a provider, visit myuhc.com or call the number on your ID card



If you need medical attention in select locations

Different countries have different rules and regulations when it comes to health care. An insurance claim has the potential to turn into a complicated maze of red tape due to language barriers, local laws, customs and norms that differ from country to country.

We remove the complexity and partner with locally licensed insurers or administrators in countries where this type of coverage is required. All you need to do is show the right ID card to receive care, or contact us to arrange payment to a provider.

If you are living in or receiving care in one of the countries listed below, you may receive and need to carry an additional insurance ID card. Simply present the locally licensed insurer or administrator ID card at the time of service. Use your UnitedHealthcare Global ID card in all other instances.

To help you understand who your locally licensed insurer or administrator is, which ID card to use and who to call for assistance in select countries, reference the chart below. You can always contact us if you have additional questions.

When you are in:	The locally licensed insurer or administrator will be:	Carry the following ID cards in this country:	For assistance, contact:
Africa	Medical Services Organization (MSO)	UnitedHealthcare Global	UnitedHealthcare Global via the information on your ID card
Australia	nib Health Funds (nib)	<ul style="list-style-type: none"> UnitedHealthcare Global nib 	nib Phone: +1.800.244.466 Phone: +61.2.4914.1156 Email: uhc@nib.com.au Online: nib.com.au/uhc
Bahrain, Jordan, Kuwait, Lebanon, Kingdom of Saudi Arabia, Oman, Qatar, United Arab Emirates	Al Sagr National Insurance Company (ASNIC) with NEXtCARE, a local third-party administrator who will process your claims and provide customer support	<ul style="list-style-type: none"> UnitedHealthcare Global ASNIC 	NEXtCARE Phone: +966.55.088.2527 Phone: +1.800.249.9997 (in the KSA only) Email: asnicare@nextcarehealth.com
Canada	Cowan	<ul style="list-style-type: none"> UnitedHealthcare Global Cowan 	Phone: +1.844.974.1469 Email: uhcgmemberservices@cowangroup.ca
Europe*, Armenia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkey, Turkmenistan	AP Companies	UnitedHealthcare Global	UnitedHealthcare Global via the information on your ID card
Japan	Emergency Assistance Japan (EAJ)	UnitedHealthcare Global	UnitedHealthcare Global via the information on your ID card
India	Paramount Health Management (PHM)	UnitedHealthcare Global	UnitedHealthcare Global via the information on your ID card
Qatar	QLM Life & Medical Insurance Company Q.P.S.C. (QLM)	<ul style="list-style-type: none"> UnitedHealthcare Global QLM 	QLM Phone: +974 44444756 Email: qlm_medical@qlm.com.qa

* Select countries, does not include Andorra, Channel Islands, Faroe Islands, Gibraltar, Holy See, Isle of Man and San Marino.

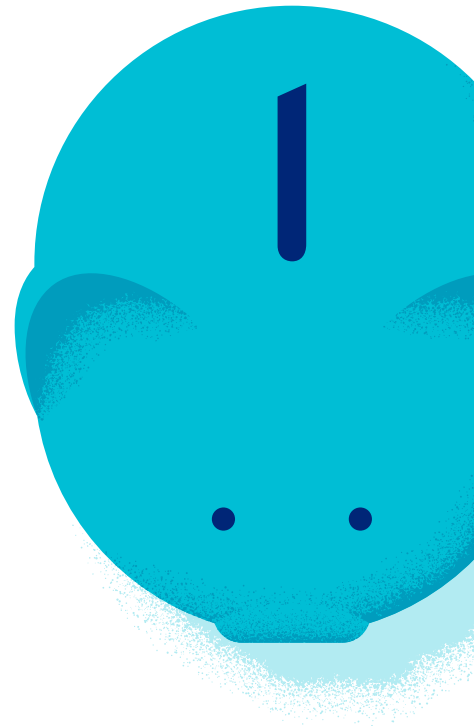
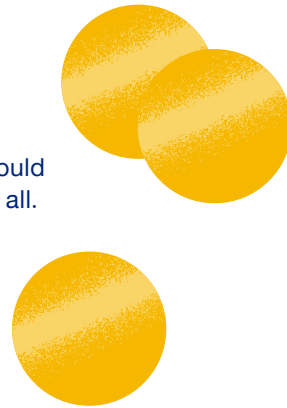
Simple ways to help you save

Here are a few good-to-know things you can do to help get the most out of your plan.

Stay in-network

The doctors and facilities in-network may have agreed to provide services at a discount—so staying in-network makes sense, especially when visiting an out-of-network provider in the U.S. could end up costing you a lot more for care or may not be covered at all. Sign in to myuhc.com > Find Care to locate:

- Labs
- Hospitals
- Mental health professionals
- Network providers



Use the direct payment system and guarantee of payment process

We have a direct payment system established with most global network providers. This means your health care bills are sent directly to us for payment, minimizing your out-of-pocket expenses and eliminating the need for you to complete a claim form.

There may be some circumstances when you need care from a provider who does not have a direct payment agreement with UnitedHealthcare Global for covered services. In this instance, the provider will need to request a guarantee of payment (GOP) from us before providing services. If a GOP is required, instruct the provider to contact the phone number on your ID card so we can issue a GOP and arrange a direct payment for services. They can also [email us](#). If this is urgent, instruct the provider to include the word "URGENT" in the subject line. Alternatively, you may create your own GOP to present to your provider. Simply login to myuhc.com, select View Global, then click "Arrange Payment to Provider" and follow the steps to generate your GOP.



Find the right care


Finding care is simple when you sign in to myuhc.com or use the UHC Global app. This is where you can quickly find a primary care provider (PCP), clinic, hospital or lab based on location, specialty, availability, hours of operation and more. You can even see patient ratings and view average costs before you choose a provider. If you would like more information about a provider's qualifications, call the phone number on your ID card.

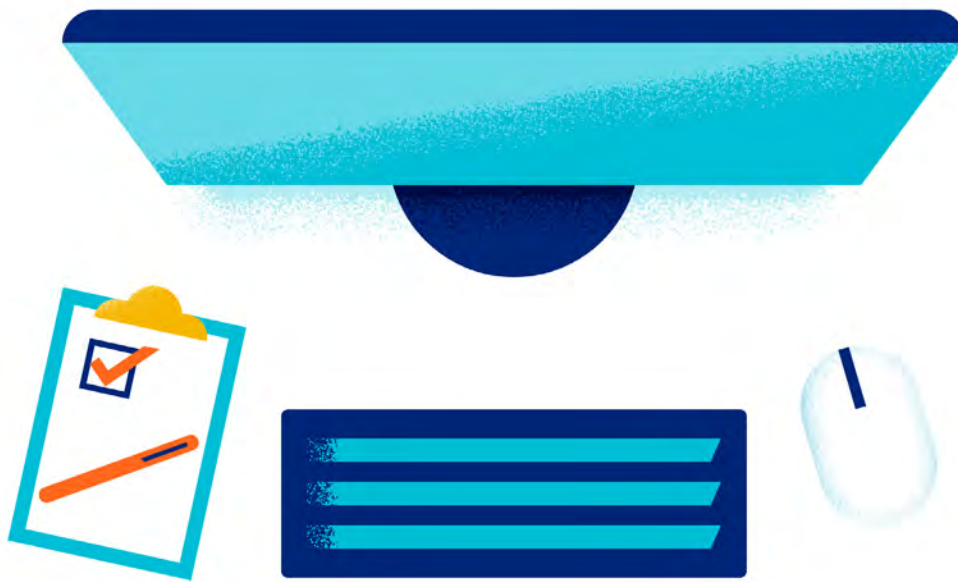
Need help finding care?

- More information on how to [find the right type of provider in the U.S.](#)
- More information on how to [find a provider outside of the U.S.](#)
- Visit myuhc.com or call the number on your ID card if you need additional assistance



Choosing a provider in the U.S.

The UnitedHealth Premium® program uses national, evidence-based, standardized measures to evaluate physicians in various specialties to help you locate quality providers. Find UnitedHealth Premium Care Physicians by going to myuhc.com > Find Care & Costs and look for blue hearts. 



Try a Virtual Visit

Seeing a doctor at home and on assignment should be simple. From treating colds and fevers, to caring for migraines and allergies—a Virtual Visit can be a great option. Sign in to myuhc.com or use the UnitedHealthcare Global app to find and connect with a doctor.

Learn more about [Virtual Visits](#).

Keep up on preventive care

Preventive care — such as routine wellness exams and certain recommended screenings and immunizations — is covered by most of our plans at no additional cost when you see an in-network provider. A preventive care visit may be a good time to help establish your relationship and create a connection for future medical services.

Need help finding out what services are covered? You have three options:

1. View your benefit summary
2. Log in to myuhc.com or the UHC Global app
3. Call the number on your ID card



Need help in an emergency?

If you're in an emergency abroad, you'll need to know how to contact the police, an ambulance or even the fire department. Follow the "first call" protocol for the country you are in. [View for a complete listing of international emergency contact numbers by country.](#)

Submit and manage claims online

When you receive medical care, the provider may require you to pay for your care at the time of service. This is called an out-of-pocket expense and should be submitted for reimbursement.

Getting reimbursed for covered medical services is easy when you complete and submit a claim via myuhc.com or through the UHC Global app. Simply:

1. Log in to myuhc.com or the UHC Global app and select your location
2. Select “Submit a Claim”
3. Enter the required information
4. Upload information about the care received and select the attestation box
5. Submit your claim, being sure to confirm your preferred method for reimbursement. A confirmation page will appear with a submission ID number.

Each claim is different and processing times vary, but most claims are processed for payment within 14 business days. Payment processing times vary by payment method and banking institution, but in general should take no longer than 7 additional business days.

To check on the status of a claim, visit myuhc.com or the UHC Global app. From here, you can view all submitted claims, review claims payment status and reference your past claim history.

You can also subscribe to receive international claims status notifications by following these simple steps:

1. Log in to myuhc.com
2. Go to My Account > Account Settings > Communication and mailing preferences to opt into personalized emails
3. Enter your email address



Health and wellness benefits powered by care



My Wellbeing

My Wellbeing is a digital health platform designed to help you create positive behavioral changes and healthy habits.

Use it to:

- Set goals
- Create social, physical and nutrition programs
- Track your health and activity
- Stay connected and focused

Register at mywellbeingsolution.com using the company access code **uhcglobal**. Dependents can use the same code to create their account. Download the Optum® My Wellbeing app from your favorite app store.

[Learn more about My Wellbeing here.](#)



Employee Assistance Program

When life gets challenging, you've got caring, confidential help from your Employee Assistance Program (EAP).

There are three ways to access your EAP benefits:

1. Call and talk to a specialist
+1.877.510.9664 in the U.S.
+44.1865.397.074 outside the U.S.
2. Online at livewell.optum.com using company access code **uhcglobal** and view "Contact Us" from the home page
3. Download the Optum My Wellbeing app from your favorite app store and select "contact your EAP" from the home page

[Learn more about the Employee Assistance Program.](#)

Behavioral health services

Life is change. LiveWell offers programs and resources designed to help you improve your wellbeing and create the life you want. From topics such as work/life balance, building healthy relationships, coping with stress and anxiety and more, we're here to support you with whatever challenges you may experience in life. Come back each month to explore new articles, training sessions and the latest resources.

Register at livelwell.optum.com using the company access code **uhcglobal**.

Mindfulness

Mindful Matters offers live, expert-led mindfulness sessions plus on-demand content on a variety of topics, and daily mindfulness topics to help you tackle stress, ease worries or fears, and build resilience.

Register at livelwell.optum.com using the company access code **uhcglobal**.

Financial wellness

Financial Wellness Resources offer free support to help you reach your financial goals, pay down debt, and plan for retirement.

Register at livelwell.optum.com using the company access code **uhcglobal**.

Health Management Program

If you and your qualifying dependents have a complex or chronic condition, you can take advantage of the Health Management Program. This program is uniquely designed to help you access the resources you need to overcome the challenges of accessing care and resources for complex, high-risk conditions.

Here's how it works:

- Enroll by calling the number on your ID card
- A clinician will be assigned to you and will provide targeted support and assistance to help you overcome the challenges of accessing care and resources outside your home country
- They work with you to develop a long-term and trusted relationship, getting to know your case history and needs on a personal level so you can focus on getting better

[Learn more](#) about the Health Management Program here.

Assistance services

If you have a medical or travel problem, call the number on your ID card for 24/7 assistance. Reasons to call may include:

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

Daily security alerts

It's easy to stay ahead of possible risks that may impact your safety while abroad. [Sign up](#) to receive daily security alerts – emails notifying you of global developments related to terrorist threats, geopolitical strife, criminal activity and health outbreaks.

* Optional buy-up service

Here's the fine print



To protect your privacy, UnitedHealthcare Global follows rules for how we use and share your information. In addition, you have certain rights for managing your private information. To view the full Notice of Privacy Practices, [click here](#). To request a printed copy, call Customer Service at the member phone number on your health plan ID card.

We may use and share your information as we:

- Help manage your health care treatment
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests, and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement and other government requests
- Respond to lawsuits and legal actions

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of the privacy notice
- Choose someone to act for you

To exercise your rights, or if you believe your privacy rights have been violated, call the phone number on your ID card or send a written notice to:

**UnitedHealthcare
Customer Service — Privacy Unit
P.O. Box 740815
Atlanta, GA 30374-0815**

















United Healthcare Global

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Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
 <p>International and U.S. Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.</p>	
 <p>Virtual Visits Talk to a doctor 24/7 who can diagnose and treat a wide range of non-emergency medical conditions, such as colds and rashes.</p>	
 <p>Vision With this plan, you have coverage for an annual eye exam.</p>	
 <p>Preventive care covered at 100% There is no additional cost to you for seeing an International or U.S. network provider for preventive care.</p>	
 <p>Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.</p>	
 <p>Evacuation & Repatriation With our program, you are covered for certain assistance benefits and services, including medical evacuations and repatriations.</p>	
 <p>Intelligence The Global Intelligence Center provides real-time, country-specific medical and security details, risks, quality of care assessments, threats and immunizations requirements.</p>	

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

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	International	U.S. Network	U.S. Out-of-Network
Annual Medical Deductible			
Individual	You do not have to pay a medical deductible.	\$500	\$1,000
Family	You do not have to pay a medical deductible.	\$1,000	\$2,000

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

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

	International	U.S. Network	U.S. Out-of-Network
Annual Out-of-Pocket Limit			
Individual	You do not have to pay a medical out of pocket maximum.	\$2,000	\$4,000
Family	You do not have to pay a medical out of pocket maximum.	\$4,000	\$8,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year. Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	International	U.S. Network	U.S. Out-of-Network
Preventive Care Services			
Preventive Care Services	No copay	No copay	40%*
<p>Certain preventive care services are provided as specified with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible. For Out of Network benefits, the deductible does not apply to immunizations for Enrolled Dependent children from birth to age six.</p> <p>Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.</p>			
Office Services - Sickness & Injury			
Primary Care Physician	No copay	20%*	40%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.</p>			
Specialist	No copay	20%*	40%*
<p>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.</p>			

*After the Annual Medical Deductible has been met.

*Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	International	U.S. Network	U.S. Out-of-Network
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Urgent Care Center Services

No copay

20%*

40%*

Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.

Virtual Visits

No copay

No copay

40%*

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card.

Vision Exams

No copay

20%*

40%*

Limited to 1 exam every 12 months.

For U.S. Benefits find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.

Emergency Care

Ambulance Services - Emergency Ambulance

Air Ambulance

No copay

20%*

20%*

Ground Ambulance

No copay

20%*

20%*

Ambulance Services - Non-Emergency Ambulance¹

Air Ambulance

No copay

20%*

20%*

Ground Ambulance

No copay

20%*

40%*

Dental Services - Accident Only

No copay

20%*

20%*

Emergency Health Care Services - Outpatient¹

No copay

20%*

20%*

Inpatient Care

Congenital Heart Disease (CHD) Surgeries¹

No copay

20%*

40%*

Habilitative Services - Inpatient¹

The amount you pay is based on where the covered health care service is provided.

Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.

Hospital - Inpatient Stay¹

No copay

20%*

40%*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services¹

No copay

20%*

40%*

Limited to 120 days per year.

Outpatient Care

Acupuncture Services

No copay

20%*

40%*

Limited to \$2,500 per year.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	International	U.S. Network	U.S. Out-of-Network
Habilitative Services - Outpatient	No copay	20%*	40%*
<i>For outpatient therapies (physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services.</i>			
Home Health Care ¹	No copay	20%*	40%*
<i>Limited to 120 visits per year.</i>			
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>			
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing ¹	No copay	20%*	40%*
<i>Limited to 18 Definitive Drug Tests per year.</i>			
<i>Limited to 18 Presumptive Drug Tests per year.</i>			
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing ¹	No copay	20%*	40%*
Major Diagnostic and Imaging - Outpatient ¹	No copay	20%*	40%*
Physician Fees for Surgical and Medical Services	No copay	20%*	40%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	No copay	20%*	40%*
<i>Limited to 20 visits of cognitive rehabilitation therapy per year.</i>			
<i>Limited to 20 visits of manipulative treatments per year.</i>			
<i>Limited to 20 visits of occupational therapy per year.</i>			
<i>Limited to 20 visits of physical therapy per year.</i>			
<i>Limited to 20 visits of pulmonary rehabilitation therapy per year.</i>			
<i>Limited to 20 visits of speech therapy per year.</i>			
<i>Limited to 30 visits of post-cochlear implant aural therapy per year.</i>			
<i>Limited to 36 visits of cardiac rehabilitation therapy per year.</i>			
Scopic Procedures - Outpatient Diagnostic and Therapeutic	No copay	20%*	40%*
<i>Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.</i>			
Surgery - Outpatient ¹	No copay	20%*	40%*
Therapeutic Treatments - Outpatient ¹	No copay	20%*	40%*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>			

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	International	U.S. Network	U.S. Out-of-Network
Supplies and Services			
Diabetes Self-Management Items ¹	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care ¹	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies ¹	No copay	20%*	40%*
<i>Limited to a single purchase of a type of DME or orthotic every 3 years.</i>			
<i>Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.</i>			
Hearing Aids	No copay	20%*	40%*
<i>Limited to \$5,000 every year. Benefits are further limited to a single purchase per hearing impaired ear every 3 years.</i>			
<i>Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</i>			
Ostomy Supplies	No copay	20%*	40%*
Pharmaceutical Products - Outpatient	No copay	20%*	40%*
<i>This includes medications given at a doctor's office, or in a covered person's home.</i>			
Prosthetic Devices ¹	No copay	20%*	40%*
<i>Limited to a single purchase of each type of prosthetic device every 3 years.</i>			
<i>Limits apply unless there is growth or significant change in the Covered Person.</i>			
<i>Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.</i>			
Pregnancy			
Pregnancy - Maternity Services ¹	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient ¹	No copay	20%*	40%*
Outpatient ¹	No copay	20%*	40%*
Partial Hospitalization ¹	No copay	20%*	40%*
Other Services			
Cellular and Gene Therapy ¹	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	International	U.S. Network	U.S. Out-of-Network
Clinical Trials ¹	The amount you pay is based on where the covered health care service is provided.		
<i>To be a qualifying clinical trial for services outside the United States, a clinical trial must meet all of the criteria as described under Clinical Trials in the Certificate of Coverage.</i>			
Culturally Based Services	No copay	Benefits are not available	Benefits are not available
Dental Anesthesia Services - Hospitalization/Anesthesia ¹	The amount you pay is based on where the covered health care service is provided.		
Gender Dysphoria ¹	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care ¹	No copay	20%*	40%*
Reconstructive Procedures ¹	The amount you pay is based on where the covered health care service is provided.		
Temporomandibular Joint (TMJ) and Craniomandibular Disorder Services ¹	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services ¹	The amount you pay is based on where the covered health care service is provided.		
Wigs	No copay	20%*	40%*
<i>Limited to \$600 every 24 months.</i>			
Evacuation and Repatriation Services			
Emergency Evacuation ¹	Not Covered	Benefits are not available	Benefits are not available
<i>Limited to a per diem of \$300 for up to 30 days towards the living expenses incurred by the person(s) accompanying you.</i>			
<i>Services for Evacuation/Repatriation benefits are only covered if all arrangements are approved in advance and arranged by us.</i>			
Emergency Family Reunion ¹	Not Covered	Not Covered	Benefits are not available
<i>Limited to a per diem for living expenses for immediate family members of \$300 while the Covered Person is hospitalized up to 30 days.</i>			
<i>Services for Evacuation/Repatriation benefits are only covered if all arrangements are approved in advance and arranged by us.</i>			
Medical Repatriation ¹	Not Covered	Not Covered	Benefits are not available
<i>Benefits include Repatriation of Children (under age 18) and adult family members.</i>			
<i>Services for Evacuation/Repatriation benefits are only covered if all arrangements are approved in advance and arranged by us.</i>			
Repatriation of Remains ¹	Not Covered	Not Covered	Benefits are not available
<i>Benefits include Return of Children (under age 18) and adult family members.</i>			
<i>Services for Evacuation/Repatriation benefits are only covered if all arrangements are approved in advance and arranged by us.</i>			

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	International	U.S. Network	U.S. Out-of-Network
International Pharmacy Benefits			
Outpatient Prescription Drugs	No copay	Benefits are not available	Benefits are not available
<i>Prescriptions must be paid for out-of-pocket and submitted to us for reimbursement.</i>			

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

U.S. Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

U.S. In Network and Out of Network

Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	U.S. Retail Network	U.S. Out-of-Network Pharmacy	U.S. Mail Order Network Pharmacy**
Tier 1 \$	\$10	40%	\$25
Tier 2 \$\$	\$20	40%	\$50
Tier 3 \$\$\$	\$30	40%	\$75

* After the Annual Pharmacy Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

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

Other important information about your benefits.

Medical Exclusions

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

- Bariatric Surgery
- Cosmetic Surgery
- Glasses
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

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 based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

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

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

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

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

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

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Experimental or Investigational or Unproven Services and medications. This exclusion does not apply to Prescription Drug Products that have been approved by the Federal Food and Drug Administration but not specifically for the treatment of certain types of cancer, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Such drugs are covered, when they are recognized for the treatment of another type of cancer, HIV or AIDS in the United States Pharmacopeia-Drug Information or in medical literature.
- 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.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Prescription Drug Products when prescribed to treat infertility unless required by state law.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Drugs available over-the-counter.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.

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

If you think you weren't treated fairly 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, UT 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, 1-800-537-7697 (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 others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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 русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تويوغلل اددع اسم الما تادخد ناف، (Arabic) ةيبرعل ا شحت تنك اذ: هي بنت
ىل ع جردملا ين اجمال فتا امل مقرب ل اصل ا ل اى جري. اقل ع اتم ةين اجمال
اكتب قص اخل ا فير ع امل ا قاطب

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisyè 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.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, नःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन 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.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (**Greek**), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

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

DÍI BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqódí ninaaltsoos nitl'izi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh 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.

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિપર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

	NON-ORTHODONTICS		ORTHODONTICS	
	INT'L / NETWORK	NON-NETWORK	INT'L / NETWORK	NON-NETWORK
Individual Annual Deductible	\$25	\$25	\$0	\$0
Family Annual Deductible	\$75	\$75	\$0	\$0
Annual Maximum Benefit <i>(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)</i>	\$1500 per person per Calendar Year	\$1500 per person per Calendar Year	\$1500 per person per Lifetime	\$1500 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No (In-Network / Out-of-Network)			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Children and Adults			

COVERED SERVICES*	INT'L / NETWORK	NON-NETWORK	BENEFIT GUIDELINES
	PLAN PAYS**	PLAN PAYS***	
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	100%	
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations (Amalgam or Anterior Composite)*	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	80%	80%	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	80%	80%	When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery - Brush Biopsy	80%	80%	
Oral Surgery - Surgical Extractions	80%	80%	
Oral Surgery - Partial/Bony	80%	80%	
Oral Surgery - Other	80%	80%	
Endodontics - Pulpotomy	80%	80%	
Endodontics - Other	80%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Periodontal Maintenance	80%	80%	Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Periodontics - Non Surgical	80%	80%	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	80%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	80%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dental Implants	50%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

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

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

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

For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

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

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

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- C. The least costly, clinically accepted treatment; and
- D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

1. PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.
2. COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.
3. BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.
4. EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
5. DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.
6. FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
7. SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
9. RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
10. PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. POST AND CORES Covered only for teeth that have had root canal therapy.
14. SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.
16. ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
17. PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
18. FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
21. REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
22. PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
24. FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
25. GENERAL ANESTHESIA Covered only when clinically necessary.
26. OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
27. PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
28. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
29. CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

GENERAL EXCLUSIONS

21. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situated in the state of Arizona, in order to comply with state regulations.
22. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
25. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
26. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.



Plan A

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

In-network, covered-in-full benefits include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating¹ and the frame, or contact lenses in lieu of eye glasses.

Copays for in-network services		
Exam		\$0.00
Materials		\$0.00
Benefit frequency		
Comprehensive Exam		Every 12 months
Spectacle Lenses		Every 12 months
Frames		Every 12 months
Contact Lenses in Lieu of Eye Glasses		Every 12 months
Frame benefit		
Network Provider		\$130.00 retail frame allowance
Lens options		
Standard scratch-resistant coating, tints, ultraviolet coating, polycarbonate, as well as standard and deluxe progressive lenses are covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)		
Contact lens benefit		
<p>Covered-in-full elective contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full. If you choose disposable contacts, up to 6 boxes are included when obtained from a network provider.</p> <p>All other elective contact lenses A \$150.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection. Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.</p> <p>Necessary contact lenses³ Covered in full.</p>		
Out-of-network reimbursements	U.S. Non-Network Benefits	International Benefits*
Exam	\$40.00	Up to \$80.00
Frames	\$45.00	Up to \$110.00
Single Vision Lenses	\$40.00	Up to \$60.00
Bifocal Lenses	\$60.00	Up to \$80.00
Trifocal Lenses	\$80.00	Up to \$115.00
Lenticular Lenses	\$80.00	Up to \$130.00
Elective Contacts in Lieu of Eye Glasses ²	\$105.00	Up to \$150.00
Necessary Contacts in Lieu of Eye Glasses ³	\$210.00	Up to \$210.00
Laser vision benefit		
UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik <i>Plus</i> locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com .		

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

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

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

*International Benefits receive out of network only. No other benefits or patient options are to be administered.

Important to Remember:

- Benefit frequency based on last date of service.
- Your \$150.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30.00, you will have \$120.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- Medically necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming how much of a reimbursement you can expect to receive before you purchase such contacts.
- **Out-of-Network Reimbursement, when applicable:** Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: Global Solutions Service Center, P.O. Box 740111, Atlanta, GA 30374-0111
- UnitedHealthcare Vision offers an Additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

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

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

UnitedHealthcare Vision® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates.

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