UnitedHealthcare® Global

Benefit Summary

Delaware - Choice Plus
Expatriate Insurance - Plan 1969A

What is a benefit summary?

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

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

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

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

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

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

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

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

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

Are you a member?

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

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

Benefits At-A-Glance

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

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

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
International: You have no co-payment.	International: You have no individual deductible.	International: 20%
U.S. Network: $20	U.S. Network: $2,000	U.S. Network: 20%

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

UnitedHealthcare Insurance Company

Your Costs

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

	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Annual Deductible		
What is an annual deductible?		
The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.		
> Your co-pays do not count towards meeting the deductible unless otherwise described within the specific covered health care service.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	International: You do not have to pay a medical deductible. U.S. Network: $2,000 per year	$4,000 per year
Medical Deductible - Family	International: You do not have to pay a medical deductible. U.S. Network: $4,000 per year	$8,000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	International: $2,000 per year U.S. Network: $4,000 per year	$8,000 per year
Out-of-Pocket Limit - Family	International: $4,000 per year U.S. Network: $8,000 per year	$16,000 per year

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

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

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

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

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

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Acupuncture Services		
Limited to $2,500 per year.	International: You pay nothing. A deductible does not apply. U.S. Network: $20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency Ambulance:	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the U.S. network medical deductible has been met.
Non-Emergency Ambulance:	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder Services		
	The amount you pay is based on where the covered health care service is provided.	
		Prior Authorization is required.
Cellular and Gene Therapy		
	The amount you pay is based on where the covered health care service is provided.	Benefits are not available.
	For U.S. Network Benefits, Prior Authorization is required.	

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Clinical Trials		
To be a qualifying clinical trial for services outside the United States, a clinical trial must meet all of the criteria as described under Clinical Trials in the Certificate of Coverage.	The amount you pay is based on where the covered health care service is provided.	
	For U.S. Network Benefits, Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Culturally-Based Services		
Services provided outside the United States that reflect the medical standards of the country in which the service is provided, but which may otherwise be considered alternative treatments when provided within the United States as described under Culturally-Based Services in the Certificate of Coverage.	International: 20% co-insurance. A deductible does not apply. U.S. Network: Benefits are not available.	Benefits are not available.
Dental Services - Accident Only		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the U.S. network medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self-Management Items: For insulin drugs the total amount of Co-payment and/or Co-insurance shall not exceed $100 for an individual prescription up to a 30-day supply not subject to the deductible.	International: The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Benefit. U.S. Network and Out-of-Network Benefits: The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Rider.	Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
Limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for DME or orthotics that costs more than $1,000.

Your Costs

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

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Emergency Health Care Services - Outpatient		
	International: You pay nothing. A deductible does not apply. U.S. Network: $300 co-pay per visit. A deductible does not apply.	$300 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Gender Dysphoria		
	International: The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Benefit. U.S. Network and Out-of-Network Benefits: The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.	
	For U.S. Network Benefits, Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment. Benefit limits stated above do not apply to physical therapy and for Manipulative Treatment for the treatment of back pain. Co-payments and Co-insurance for Covered Health Services provided within the scope of a Doctor of Chiropractic's license will not exceed 25% of the fee to be paid to the Doctor of Chiropractic. Co-payments and Co-insurance for Covered Health Services provided within the scope of a Physical Therapist for Physical Therapy care or services will not exceed 25% of the fee to be paid to the Physical Therapist.	International: You pay nothing for manipulative treatment. A deductible does not apply. You pay nothing for all other habilitative services. A deductible does not apply. U.S. Network: 20% co-insurance for manipulative treatment. A deductible does not apply. $20 co-pay per visit for all other habilitative services . A deductible does not apply.	25% co-insurance for manipulative treatment. A deductible does not apply. 40% co-insurance for all other habilitative services, after the medical deductible has been met. Prior Authorization is required for certain Inpatient services.
Hearing Aids		
Limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Home Health Care		
Limited to 120 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive U.S. Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Iatrogenic Infertility Services		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
	For U.S. Network Benefits, Prior Authorization is required.	Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.
Major Diagnostic and Imaging - Outpatient		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Medical Foods		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Medical Repatriation		
Benefits include Repatriation of Children (under age 18) and adult family members.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply. You must notify us to obtain Benefits for medical repatriation. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.	Benefits are not available.
	After you receive initial treatment and stabilization for a Sickness or Injury, if the attending Physician and our Medical Director or the Medical Director of our affiliate or authorized vendor under our direction determine that it is appropriate to facilitate your recovery, we will transport you back to your permanent place of residence for further medical treatment or to recover. The timing and method of transportation will be determined solely by us and will be suitable to accommodate your medical needs. Covered Services include arranging and providing for transportation and related medical services (including medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.	

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient: Initial depression screening is covered at 100% for In-Network only.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Outpatient: Initial depression screening is covered at 100% for In-Network only.	International: You pay nothing. A deductible does not apply. U.S. Network: $20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment: Initial depression screening is covered at 100% for In-Network only.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.
Ostomy Supplies		
Limited to $2,500 per year.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Outpatient Prescription Drugs		
For U.S. Network and Out-of-Network Benefits are provided as described in your Outpatient Prescription Drug Rider.	International: 20% co-insurance. A deductible does not apply. U.S. Network: Benefits are not available.	Benefits are not available.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Physician Fees for Surgical and Medical Services		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit:	International: You pay nothing for a primary care physician office visit. A deductible does not apply. U.S. Network: $20 co-pay per visit for a primary care physician office visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit:	International: You pay nothing for a specialist office visit. A deductible does not apply. U.S. Network: $40 co-pay per visit for a specialist office visit. A deductible does not apply.	
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of Manipulative Treatments. Limits do not apply to physical therapy, occupational therapy and speech therapy required for the treatment of Autism Spectrum Disorder for Covered Persons under age 21. Co-payments and Co-insurance for Covered Health Care Services provided within the scope of a Doctor of Chiropractic's license will not exceed 25% of the fee to be paid to the Doctor of Chiropractic. Copayments and Coinsurance for Covered Health Services provided within the scope of a Physical Therapist for Physical Therapy care or services will not exceed 25% of the fee to be paid to the Physical Therapist.	International: You pay nothing for manipulative treatment. A deductible does not apply. You pay nothing for all other rehabilitation services. A deductible does not apply. U.S. Network: 20% co-insurance for manipulative treatment. A deductible does not apply. $20 co-pay per visit for all other rehabilitation services . A deductible does not apply.	25% co-insurance for manipulative treatment. A deductible does not apply. 40% co-insurance for all other rehabilitation services, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Repatriation of Remains		
Benefits include Return of Children (under age 18) and adult family members. In the event of your death, we or our affiliate or authorized vendor will render assistance and provide for the return of your mortal remains to your permanent place of residence.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply. You must notify us to obtain Benefits for repatriation of remains. If you don't notify us, you will be responsible for paying all charges and no benefits will be paid.	Benefits are not available.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 120 days per year.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Surgery - Outpatient		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Temporomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required for Inpatient Stay.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
	The amount you pay is based on where the covered health care service is provided. For International and U.S. Network Benefits, Prior Authorization is required.	Benefits are not available.
Urgent Care Center Services		
	International: You pay nothing. A deductible does not apply. U.S. Network: $50 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	International: You pay nothing. A deductible does not apply. U.S. Network: You pay nothing. A deductible does not apply.	Benefits are not available.

Your Costs

Covered Health Care Services	Your cost if you use International and U.S. Network Benefits	Your cost if you use U.S. Out-of-Network Benefits
Vision Exams		
For U.S. Benefits find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 12 months.	International: You pay nothing. A deductible does not apply. U.S. Network: $20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Wigs		
	International: 20% co-insurance. A deductible does not apply. U.S. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.

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

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

For Internal Use only:

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999-0064	1019_rev03	Expatriate Insurance/Sep/Emb/47314/2019

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 Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

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

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

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 others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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 идентификационной карте.

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.

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

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

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

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

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

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

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