



# CITGO PETROLEUM CORPORATION BUSINESS TRAVEL WELCOME KIT

# Here is your UnitedHealthcare Global ID Card

## WORLDWIDE 24-HOURS A DAY

When traveling, you can now feel confident that you are in safe hands if an emergency arises.

UnitedHealthcare Global provides medical, security and travel-related assistance services.

Always carry your Identification Card with you. Listed on the back of the card are the telephone numbers for the worldwide UnitedHealthcare Global network. When you call, be prepared to provide your ID number, organization's name, your name and a description of the situation.

### MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals  
Monitoring of Treatment  
Facilitation of Hospital Payments  
Transfer of Insurance Information to Medical Providers  
Medication and Vaccine Transfers  
Dispatch of Doctors and Specialists  
Transfer of Medical Records  
Continuous Updates to Family, Employer and Home Physician  
Hotel Arrangements for Convalescence  
Replacement Corrective Lenses and Medical Devices

### TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents  
Emergency Travel Arrangements  
Transfer of Funds  
Legal Referrals  
Translation Services  
Message Transmittals

### WORLDWIDE DESTINATION INTELLIGENCE

Pre-Travel Information  
Travel and Health Information  
Security Intelligence

### NATURAL DISASTER SERVICES

Natural Disaster Evacuation  
Transportation to Departure Points  
Transportation After Natural Disaster Evacuation

### MEDICAL EVACUATION AND REPATRIATION SERVICES

Emergency Medical Evacuations  
Transportation to Join a Hospitalized Member  
Return of Dependent Children  
Transportation After Stabilization  
Repatriation of Mortal Remains

### PERSONAL SECURITY SERVICES

Political Evacuation Services  
Security Evacuation Services  
Transportation After Political or Security Evacuation

### FREQUENTLY ASKED QUESTIONS:

**WHO IS UNITEDHEALTHCARE GLOBAL?** UnitedHealthcare Global assists travelers worldwide by utilizing highly trained, multilingual coordinators in conjunction with an extensive information and communication system to provide medical and travel-related assistance.

**WHEN SHOULD I CONTACT UNITEDHEALTHCARE GLOBAL?** Coordinators are available 24-hours a day, every day of the year. Many times people assume that the services are to be used only in serious cases. Be assured that UnitedHealthcare Global is there to help you with any type of problem regardless of the severity.

**WHAT IF LOCAL MEDICAL FACILITIES ARE INADEQUATE?** If, through our medical management, it is determined that local medical providers are inappropriate for treatment, UnitedHealthcare Global will arrange for a medically safe evacuation to a facility capable of providing the necessary care.

**WHAT HAPPENS IF I AM HOSPITALIZED?** It is important to notify UnitedHealthcare Global as soon as possible so your treating physician can be contacted to assess your condition and treatment plans to ensure your safe recovery. UnitedHealthcare Global will then update your family, employer/organization and personal physician as appropriate and assist you until you have returned home or have received final treatment.

*Detach and carry with you at all times.*



**BUSINESS TRAVEL  
INSURANCE**

Client Name: CITGO Petroleum Corporation

Group ID#: 908129  
(Provide this number when calling Customer Service)

Member ID# 902233570  
(Use this number when creating your Intelligence Center)

UnitedHealthcare Business Travel Insurance  
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.

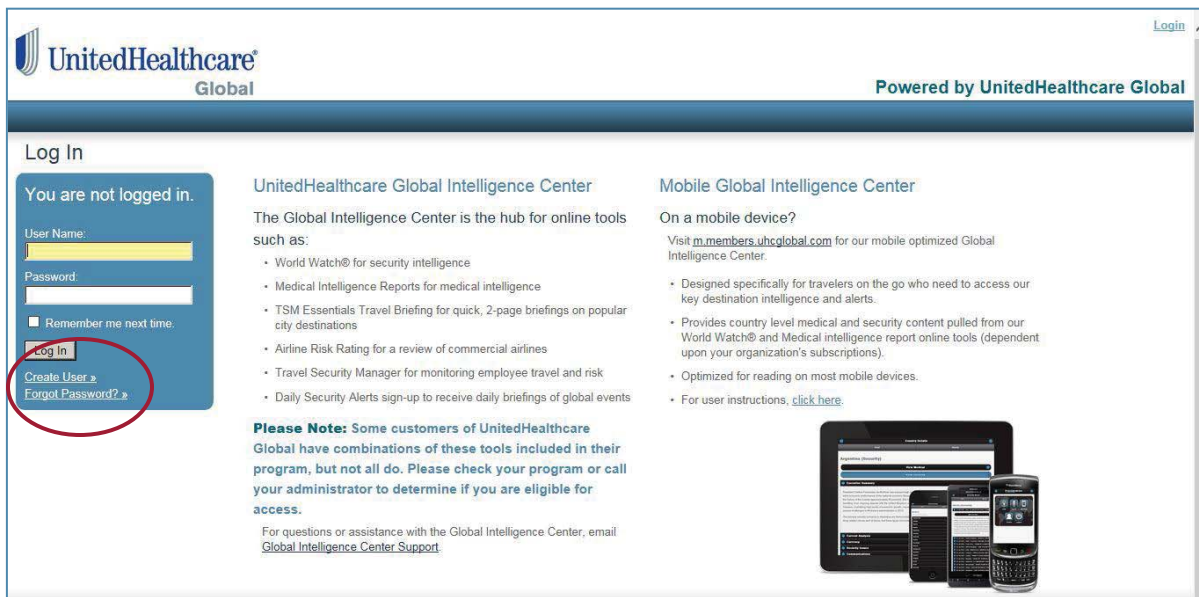
**Business Travel Toll Free:** + 1 866-870-3475  
**Business Travel Reverse Charges Accepted:** +1-763-274-7364  
businessstravel@uhcglobal.com  
<http://members.uhcglobal.com>

**Claim Submission:**  
UnitedHealthcare Global  
PO Box 740836  
Atlanta, GA 30374-0836 USA  
Fax: +1-248-524-5729  
businessstravel@uhcglobal.com

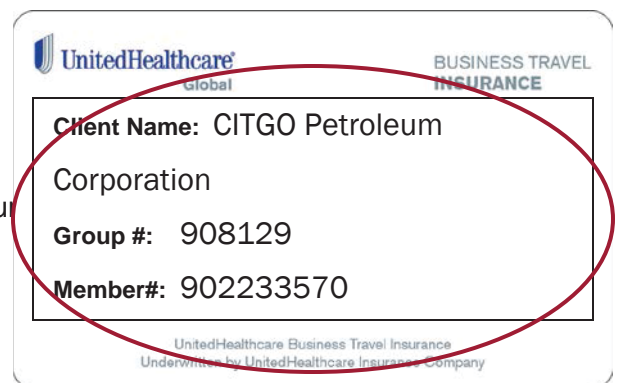
**Notice to Physicians/Hospitals:** Call immediately for benefits verification and procedures. Call 24 hours a day (multilingual). If you do not have access to a phone, email [businessstravel@uhcglobal.com](mailto:businessstravel@uhcglobal.com).

## Creating a UnitedHealthcare Global Intelligence Center Account

Follow the steps below to create your Global Intelligence Center account, giving you access to detailed travel, medical and security information.



1. Go to <https://members.uhcglobal.com>.
2. Click on "Create User"
3. Enter your Member ID Number, found on your UnitedHealthcare Global ID card. Click Next.
4. Read and agree to the Terms of Use. Click Next.
5. Complete your Account Information: Username, Password, Email, Security Question and Answer. Click Next.
6. Complete your User Information: First Name, Last Name, Gender, Date of Birth, and Primary Phone. Click Finish.



# UnitedHealthcare Global Business Travel Insurance

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

**Claim Type(s):**  Medical  Pharmacy/RX

**Address:**

UnitedHealthcare Global  
PO Box 740836  
Atlanta, GA 30374 - 0836

**Email:**

businesstravel@uhcglobal.com

**Direct Dial Fax:**

+1 248-524-5729

**Website:**

Submit Claims online  
at <http://members.uhcglobal.com>

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

**Please complete a new and separate claim form for:**

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

**Questions? Call Member Services: 866-870-3475 / Collect +1 763-274-7364**

## Section 1 – Member and Patient Information

Client name (As appears on ID card) \_\_\_\_\_

Group number (As appears on ID card) \_\_\_\_\_

Member name \_\_\_\_\_ Member ID (if available) \_\_\_\_\_

Patient name \_\_\_\_\_ Patient relationship \_\_\_\_\_

Patient date of birth (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Member phone # \_\_\_\_\_

Member E-mail address \_\_\_\_\_

Street \_\_\_\_\_ Town/city \_\_\_\_\_

Region / State \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

Is the patient covered under another insurance health plan? Yes \_\_\_\_ No \_\_\_\_

If Yes: Name address and phone number of other insurance carrier \_\_\_\_\_

## Section 2 – Claim Information

Provider/facility name \_\_\_\_\_

Provider/facility correspondence address:

Street \_\_\_\_\_ Town/city \_\_\_\_\_

Region / State \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

In which city did the treatment take place? \_\_\_\_\_ Which country? \_\_\_\_\_

## Section 2 continued...

In what type of currency is the bill submitted? \_\_\_\_\_ Date(s) of service(s) mm/dd/yyyy: \_\_\_\_\_

Reimburse: Member \_\_\_\_\_ Provider \_\_\_\_\_ Other \_\_\_\_\_ If Other selected, please provide name \_\_\_\_\_

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

Check the type of service(s) rendered:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Office visit            | <input type="checkbox"/> Outpatient surgery    | <input type="checkbox"/> Prescription drugs |
| <input type="checkbox"/> Inpatient hospital care | <input type="checkbox"/> Emergency room visit  | <input type="checkbox"/> Medical supplies   |
| <input type="checkbox"/> Inpatient surgery       | <input type="checkbox"/> Lab or X-ray services | <input type="checkbox"/> Other              |

If Other, please briefly describe service:

A brief explanation of the purpose of your healthcare provider visit:

A brief explanation of the services rendered and/or procedures performed:

Are the services provided related to an accident? Yes \_\_\_\_\_ No \_\_\_\_\_. If "Yes", please provide details \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Section 3 – Member Reimbursement Options

**Note - If no selection is made, reimbursement will be via a US dollar check.**

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

Specify currency for reimbursement \_\_\_\_\_

For bank transfers please complete the following

Bank name \_\_\_\_\_

SWIFT / BIC Code \_\_\_\_\_

Beneficiary bank routing code \_\_\_\_\_

Account number / IBAN \_\_\_\_\_

Account name / Payee \_\_\_\_\_

Bank address \_\_\_\_\_

Would you like to keep the banking details above on file for future reimbursements? Yes \_\_\_ No \_\_\_

Any person who knowingly files a statement of claim containing any misrepresentation or false, incomplete or misleading information may be guilty of a criminal act punishable under law and subject to civil penalties.

Member Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy



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

- Benefits are available only for Eligible Expenses incurred by a member who is traveling outside his or her home country, as authorized by the Enrolling Group.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

**PLAN HIGHLIGHTS**

Types of Coverage	Benefits
<b>Annual Deductible</b>	
Individual Deductible	No Annual Deductible
Family Deductible	No Annual Deductible
<b>Benefit Plan Coinsurance - The Amount We Pay</b>	
	100%
<b>Out-of-Pocket Maximum</b>	
Individual Out-of-Pocket Maximum	No Out-of-Pocket Maximum
Family Out-of-Pocket Maximum	No Out-of-Pocket Maximum
<b>Annual Medical Maximum Benefit: Annual Medical Maximum Benefit is calculated on a Policy Year basis.</b>	
The maximum amount we will pay for medical benefits during the year.	\$500,000 per Covered Person for Medical Benefits.
<b>Additional Policy Year Benefit Information</b>	
Refer to your Certificate of Coverage for the definition of Eligible Expenses for information on how benefits are paid.	

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

**TXMt046K413**

<b>Item#</b>	<b>Rev. Date</b>	
275-7832	1114	UHC Global Travel/15326/2011

## BENEFITS

Types of Coverage	Benefits
<b>Ambulance Services - Emergency and Non-Emergency</b>	100%
	<i>Pre-Service Notification is required for non-Emergency Ambulance. Benefits under this section do not include Emergency Evacuation. See Emergency Medical Evacuation described under Evacuation and Repatriation Benefits in this Benefit Summary.</i>
<b>Culturally-Based Services</b>	100%
<b>Dental Pain Relief</b>	100%
Benefits are limited to: \$1,250 per year	
<b>Dental Services - Accident Only</b>	100%
Benefits are limited to: \$2,500 per year	
<b>Durable Medical Equipment</b>	100%
<b>Emergency Health Services - Outpatient</b>	100%
<b>Hospital - Inpatient Stay</b>	100%
<b>Lab, X-Ray and Diagnostics - Outpatient</b>	100%
<b>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>	100%
<b>Outpatient Prescription Drugs</b>	100%
<b>Pharmaceutical Products - Outpatient</b>	100%
This includes medications administered in an outpatient setting or in the Physician's Office.	
<b>Physician Fees for Surgical and Medical Services</b>	100%
<b>Physician's Office Services - Sickness and Injury</b>	100%
Primary Physician Office Visit	100%
Specialist Physician Office Visit	100%
<b>Pregnancy - Complications of Pregnancy only</b>	Benefits will be the same as those stated under each Covered Service category in this Benefit Summary.
<b>Prosthetic Devices</b>	100%



Types of Coverage	Benefits
<b>Reconstructive Procedures</b>	
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>	
Diagnostic scopic procedures include, but are not limited to: <ul style="list-style-type: none"> <li>Colonoscopy</li> <li>Sigmoidoscopy</li> <li>Endoscopy</li> </ul>	100%
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>	
	100%
<b>Surgery - Outpatient</b>	
	100%
<b>Therapeutic Treatments - Outpatient</b>	
Therapeutic treatments include, but are not limited to: <ul style="list-style-type: none"> <li>Dialysis</li> <li>Intravenous chemotherapy or other intravenous infusion therapy</li> <li>Radiation oncology</li> </ul>	100%
<b>Urgent Care Center Services</b>	
	100%



## EVACUATION AND REPATRIATION BENEFITS

Types of Coverage	Benefits
<b>Annual Evacuation and Repatriation Maximum Benefit</b>	
The maximum amount we will pay for evacuation and repatriation benefits during the year.	\$250,000 per Covered Person for Evacuation and Repatriation Benefits.
<b>Emergency Medical Evacuation</b>	
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.	100%  Transportation for 1 person to join the Covered Person at the location where the Covered Person is transported. A per-diem of \$750 daily for up to 14 days to cover accommodation for the Covered Person or the person accompanying the Covered Person at the evacuation destination. 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.  <i>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.</i>
<b>Emergency Family Reunion</b>	
	100%  In the event that you are hospitalized and in a critical or terminal condition, or upon your death, benefits are available to transport two (2) of your family members to join you. We will provide a per-diem of \$750 to cover accommodation expenses for your family members up to a maximum of fourteen (14) days.  <i>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.</i>
<b>Medical Repatriation</b>	
Benefits include Repatriation of Children (under age 18).	100%  After you receive initial treatment and stabilization for a Sickness or Injury, if the attending Physician and our <i>Medical Director</i> or the <i>Medical Director</i> 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.  <i>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.</i>

**Types of Coverage**

**Benefits**

**Repatriation of Remains**

Benefits include Return of Children (under age 18). 100%

In the event of your death, we or our affiliate or authorized vendor will render assistance and provide for the return of your mortal remains to your permanent place of residence.

*You must notify us 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.*

THIS POLICY IS SUPPLEMENTAL TO A GROUP HEALTH PLAN. IT IS NOT A MAJOR MEDICAL OR COMPREHENSIVE MEDICAL POLICY.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

## EXCLUSIONS

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

### Alternative Treatments

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

### Dental

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

### Devices, Appliances and Prosthetics

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

### Drugs

Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

### Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

### Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

### Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, urinary catheters, Ostomy supplies. This exclusion does not apply to disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

## EXCLUSIONS CONTINUED

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### Mental Health

Services for the treatment of mental illness or mental health conditions:

### Neurobiological Disorders – Autism Spectrum Disorders

Services for treatment of autism spectrum disorders as the primary diagnosis. (Autism spectrum disorders are a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).)

### Nutrition

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

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

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

### Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

### Physical Appearance

Cosmetic Procedures. See the definition in Section 8 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

### Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy and vision therapy. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. Breast reduction surgery except as described under Reconstructive Procedures in Section 1 of the COC.

### Providers

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

## EXCLUSIONS CONTINUED

### Reproduction

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

### Services Provided under another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, Defense Base Act (DBA) coverage, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty. Health services provided while you are covered under a separate policy issued through your Enrolling Group as stipulated by a foreign governmental requirement. Health services provided under your primary medical plan.

### Substance Use Disorders

Services for the treatment of substance use disorder services.

### Transplants

Health services for organ and tissue transplants. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person.

### Travel

Travel or transportation expenses, even though prescribed by a Physician. This exclusion does not apply to Emergency Evacuation, Medical Repatriation and Repatriation of Remains for which Benefits are described under Evacuation and Repatriation Benefits in Section 1 of the COC.

### Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care or maintenance care. Domiciliary care. Private Duty Nursing. Respite care. Rest cures. Services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work). Home Health Care. Hospice Care. Preventive medical care.

### Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Routine vision examinations, including refractive examinations to determine the need for vision correction. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

### All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Service – see the definition in Section 8 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Subscribers who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Sign language and foreign language services.

# Accidental Death and Dismemberment Rider

## UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides benefits for accidental death and dismemberment, as described below.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 8: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 8: Defined Terms*.

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(Name and Title)

## Benefits for Accidental Death and Dismemberment

If the Covered Person suffers a loss described below, we will pay the amount of insurance that applies. The Covered Person or Covered Person's beneficiary, must give us proof of all of the following:

- Injury occurred while the insurance was in force under this section.
- Loss occurred within 90 days after the Injury.
- Loss was due to Injury independent of all other causes.

Amount of Insurance: \$100,000 will be paid according to the following table:

*Include conditions in table and explanations directly below according to plan design.*

Loss of life	100%
Loss of both hands or both feet	50%
Loss of sight of both eyes	50%
Loss of one hand and sight of one eye	50%
Loss of one foot and sight of one eye	50%
Quadriplegia	25%
Paraplegia	25%
Triplegia	25%
Loss of one hand	25%
Loss of one foot	25%
Loss of sight of one eye	25%
Coma	25%
Loss of speech	25%
Loss of hearing	25%
Hemiplegia	25%
Uniplegia	25%
Loss of thumb and index finger of the same hand	25%

Loss of sight means total and irrecoverable loss of sight. Loss of hands or feet means severance at or above the wrist or ankle. Loss of thumb and index finger means the actual, complete and permanent severance through or above the metacarpophalangeal joints. Loss of speech means the total and irrecoverable loss of speech. Loss of hearing means total and irrecoverable loss of hearing.

Quadriplegia means total and permanent paralysis of both upper and lower limbs. Paraplegia means total and permanent paralysis of both lower limbs. Uniplegia means the total and permanent paralysis of one limb. Triplegia means the total and permanent paralysis of three limbs. Hemiplegia means total and permanent paralysis of upper and lower limbs on one side of the body. Paralysis means permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity.

Paralysis must be the result of an Injury to the brain or spinal cord and without the severance of a limb. Coma means the diagnosis of a state of unconsciousness for a continuous period of at least 90 days.

In paying this benefit, we will consider only losses sustained while insured under this Rider. We will pay no more than the full amount shown above for losses resulting from any one Injury.

Limitations: We will not pay a benefit under this Rider for a loss caused directly or indirectly by any of the following:

- Disease, bodily or mental infirmity, or medical or surgical treatment of these.
- Suicide or intentionally self-inflicted Injury, while sane or insane.



- Participation in a riot or insurrection, or commission of an assault or felony.
- War or any act of war, declared or undeclared.
- Use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician.
- Driving while intoxicated, as defined by the applicable state law where the loss occurred.
- Engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping or using off-road vehicles.
- Injury arising out of or in the course of any occupation or employment for pay or profit, or any Any Injury or Sickness for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law.
- Travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on either a scheduled route or a charter flight seating 15 or more people.
- Travel or flight in, or descent from any aircraft, except if employment duties require the Covered Person to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on either a scheduled route or a charter flight seating 15 or more people.

**Notice of Claim:** Written notice of a claim for death or Injury must be given to us at our home office by the Covered Person or his beneficiary within 30 - 90 days of the date of death or the date the Injury occurred. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's Enrolling Group, or can requested from us. If the Covered Person does not receive the form from us within 15 - 30 days of his or her request, written proof of claim should be sent to us without waiting for the form. Written proof should establish facts about the claim such as date of occurrence, nature, and extent of the loss involved.

**Proof of Claim:** Written proof of claim must be filed within 90 days of the loss. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

**Physical Examination and Autopsy:** We have the right to have a Physician of our choice examine the Covered Person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.