

**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 Choice Plus Plan?**

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

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 if you need to go out of the network.** 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% in our network.**

**Are you a member?**

Easily manage your benefits online at [myuhc.com](http://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.

**Not enrolled yet?** Learn more about this plan and search for network doctors or hospitals at [welcometouhc.com/choiceplus](http://welcometouhc.com/choiceplus) or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

**Benefits At-A-Glance**

**What you may pay for network care**

This chart is a simple summary of the costs you may have to pay when you receive care in the 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.

<b>Co-payment</b>	<b>Individual Deductible</b>	<b>Co-insurance</b>
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
\$30	\$2,500	20%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), 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.

## 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 Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Annual Deductible</b>		
<b>What is an annual deductible?</b>		
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.		
<ul style="list-style-type: none"><li>&gt; Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.</li><li>&gt; 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.</li><li>&gt; This benefit plan includes a per occurrence deductible that applies to certain covered health care services. This per occurrence deductible must be met prior to and in addition to the medical deductible.</li></ul>		
Medical Deductible - Individual	\$2,500 per year	\$5,000 per year
Medical Deductible - Family	\$5,000 per year	\$10,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.	Included in your medical deductible.
<b>Out-of-Pocket Limit</b>		
<b>What is an out-of-pocket limit?</b>		
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.		
<ul style="list-style-type: none"><li>&gt; All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.</li><li>&gt; Your co-pays, co-insurance, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.</li></ul>		
Out-of-Pocket Limit - Individual	\$5,000 per year	\$10,000 per year
Out-of-Pocket Limit - Family	\$10,000 per year	\$20,000 per year

## Your Costs

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### **What is co-insurance?**

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated on the lesser of the Allowed Amounts and the billed charges (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.

### **Want more information?**

Find additional definitions in the glossary at [justplainclear.com](http://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.

<b>Covered Health Care Services</b>	<b>Your cost if you use Network Benefits</b>	<b>Your cost if you use Out-of-Network Benefits</b>
<b>Ambulance Services</b>		
Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.  Prior Authorization is required for Non-Emergency Ambulance.	40% co-insurance, after the medical deductible has been met.  Prior Authorization is required for Non-Emergency Ambulance.
<b>Cellular and Gene Therapy</b>		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.  Prior Authorization is required.	Prior Authorization is required.
<b>Clinical Trials</b>		
	The amount you pay is based on where the covered health care service is provided.  Prior Authorization is required.	Prior Authorization is required.
<b>Congenital Heart Disease (CHD) Surgeries</b>		
	Benefits will be the same as stated under Hospital - Inpatient Stay.  Prior Authorization is required.	
<b>Dental - Anesthesia and Hospital or Facility Charges</b>		
	The amount you pay is based on where the covered health care service is provided.  Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
<b>Dental - Pediatric Services (Benefits covered up to age 19)</b>		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		

## Your Costs

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<b>Covered Health Care Services</b>	<b>Your cost if you use Network Benefits</b>	<b>Your cost if you use Out-of-Network Benefits</b>
<b>Dental - Pediatric Preventive Services</b>		
<b>Dental Prophylaxis (Cleanings)</b> Limited to two times every 12 months.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
<b>Fluoride Treatments</b> Limited to two times every 12 months.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
<b>Sealants (Protective Coating)</b> Limited to once per first or second permanent molar every 36 months.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
<b>Space Maintainers (Spacers)</b>	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
<b>Dental - Pediatric Diagnostic Services</b>		
<b>Evaluations (Check-up Exams)</b> Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
<b>Intraoral Radiographs (X-ray)</b> Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Dental - Pediatric Basic Dental Services</b>		
<b>Endodontics (Root Canal Therapy)</b>	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<b>Adjunctive Services</b>	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<u>Palliative (Emergency) Treatment:</u> Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit.		
<u>General Anesthesia:</u> Covered only when clinically Necessary.		
<u>Occlusal Guard:</u> Limited to one guard every 12 months.		
<b>Oral Surgery</b>	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<b>Periodontics</b>	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<u>Periodontal Surgery:</u> Limited to one every 36 months per surgical area.		
<u>Scaling and Root Planing:</u> Limited to one time per quadrant every 24 months.		
<u>Periodontal Maintenance:</u> Limited to four times every 12 months in combination with prophylaxis.		
<b>Minor Restorative Services (Amalgam or Anterior Composite)</b>	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<b>Simple Extractions (Simple tooth removal)</b>	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Limited to one time per tooth per lifetime.		
<b>Dental - Pediatric Major Restorative Services</b>		
<b>Crowns/Inlays/Onlays</b>	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Limited to one time per tooth every 60 months.		
<b>Removable Dentures</b>	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
(Full denture/partial denture)		
Limited to a frequency of one every 60 months.		
<b>Bridges (Fixed partial dentures)</b>	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Limited to one time every 60 months.		
<b>Implant Procedures</b>	40% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Limited to one time every 60 months.		

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Dental - Pediatric Medically Necessary Orthodontics</b>		
<p>Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.</p>	<p>40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for orthodontic treatment.</p>	<p>50% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for orthodontic treatment.</p>
<b>Dental Services - Accident Only</b>		
	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>20% co-insurance, after the network medical deductible has been met.</p>
<b>Diabetes Services</b>		
<p>Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:</p>	<p>The amount you pay is based on where the covered health care service is provided.</p>	
<p>Diabetes Self-Management Items:</p>	<p>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.</p>	<p>Prior Authorization is required for DME that costs more than \$1,000.</p>
<b>Durable Medical Equipment (DME), Orthotics and Supplies</b>		
	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for DME or orthotics that costs more than \$1,000.</p>
<b>Emergency Health Care Services - Outpatient</b>		
	<p>After you pay the \$500 per occurrence deductible per visit; you pay 20% co-insurance, after the medical deductible has been met.</p>	<p>Emergency care received from an out-of-network provider will be paid the same as the Network benefit.</p> <p>Notification is encouraged if confined in an Out-of-Network Hospital.</p>
<b>Gender Dysphoria</b>		
	<p>The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.</p> <p>Prior Authorization is required for certain services.</p>	

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Habilitative Services</b>		
<p>Inpatient: Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are limited to 60 days per year.</p>	<p>The amount you pay is based on where the covered health care service is provided.</p>	
<p>Outpatient: Outpatient therapies are limited per year as follows: 23 visits of physical therapy. 23 visits of occupational therapy. 30 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive therapy. 20 visits of Manipulative Treatments.</p>	<p>\$30 co-pay per visit. A deductible does not apply.</p>	<p>40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for certain Inpatient services.</p>
<b>Hearing Aids</b>		
<p>Limited to one hearing aid per ear every 36 months.</p>	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>40% co-insurance, after the medical deductible has been met.</p>
<b>Home Health Care</b>		
<p>To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.</p>	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required.</p>
<b>Hospice Care</b>		
	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for Inpatient Stay.</p>
<b>Hospital - Inpatient Stay</b>		
	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required.</p>



## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Lab, X-Ray and Diagnostic - Outpatient</b>		
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required for sleep studies, stress echocardiography and transthoracic echocardiogram services.
<b>Lymphedema Services</b>		
The amount you pay is based on where the covered health care service is provided.		
<b>Major Diagnostic and Imaging - Outpatient</b>		
20% co-insurance, after the medical deductible has been met.		
40% co-insurance, after the medical deductible has been met.		
Prior Authorization is required.		
<b>Mental Health Care and Substance - Related and Addictive Disorders Services</b>		
Inpatient:	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Outpatient:	\$30 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	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.		

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Obesity - Weight Loss Surgery</b>		
<p>For designated network benefits, obesity surgery must be received at a designated facility and performed by a designated physician. Network benefits include services received at a network facility that is not a designated facility and performed by a network physician that is not a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.</p>	<p>Designated Network: 20% co-insurance, after the medical deductible has been met.</p> <p>Network: 40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required.</p>	<p>40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required.</p>
<b>Ostomy Supplies</b>		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<b>Ovarian Cancer Surveillance</b>		
	The amount you pay is based on where the covered health care service is provided.	
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<b>Physician Fees for Surgical and Medical Services</b>		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<b>Physician's Office Services - Sickness and Injury</b>		
	<p>\$30 co-pay per visit for a primary care physician office visit. A deductible does not apply.</p> <p>\$60 co-pay per visit for a specialist office visit. A deductible does not apply.</p>	<p>40% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for Genetic Testing.</p>

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Pregnancy - Maternity Services</b>		
	<p>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.</p>	<p>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.</p>
<b>Prescription Drug Benefits</b>		
<p>Prescription drug benefits are shown in the Prescription Drug benefit summary.</p>		
<b>Preventive Care Services</b>		
<p>Physician Office Services, Lab, X-Ray or other preventive tests.</p>	<p>You pay nothing. A deductible does not apply.</p>	<p>30% co-insurance, after the medical deductible has been met.</p>
<p>Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), 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.</p>		
<b>Private Duty Nursing</b>		
	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>40% co-insurance, after the medical deductible has been met. Prior Authorization is required.</p>
<b>Prosthetic Devices</b>		
	<p>20% co-insurance, after the medical deductible has been met.</p>	<p>40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than \$1,000.</p>
<b>Reconstructive Procedures</b>		
	<p>The amount you pay is based on where the covered health care service is provided.</p>	<p>Prior Authorization is required.</p>

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</b>		
Limited to: 23 visits of physical therapy. 23 visits of occupational therapy. 30 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of Manipulative Treatments.	\$30 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Limited to 60 days per year.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.  Prior Authorization is required.
<b>Surgery - Outpatient</b>		
	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.
<b>Temporomandibular Joint (TMJ) Services</b>		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required for Inpatient Stay.
<b>Therapeutic Treatments - Outpatient</b>		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	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.
<b>Transplantation Services</b>		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.  Prior Authorization is required.	Prior Authorization is required.

## Your Costs

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Urgent Care Center Services</b>		
	\$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.		
<b>Virtual Visits</b>		
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 <sup>®</sup> 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.	\$10 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Please note: coverage under this item is not provided as part of Essential Health Benefits or as a state mandate.		

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Vision - Pediatric Services (Benefits covered up to age 19)</b>		
Find a listing of Spectera Eyecare Network Vision Care Providers at <a href="http://myuhevision.com">myuhevision.com</a> .		
<b>Routine Vision Exam</b> Limited to once every 12 months.	\$10 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
<b>Eyeglass Lenses</b> Limited to once every 12 months.	\$25 co-pay. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
<b>Lens Extras</b> Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.	You pay nothing, after the medical deductible has been met.
<b>Eyeglass Frames</b> Limited to once every 12 months.		
Eyeglass frames with a retail cost up to \$130.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between \$130 - 160.	\$15 co-pay. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between \$160 - 200.	\$30 co-pay. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between \$200 - 250.	\$50 co-pay. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than \$250.	40% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
<b>Contact Lenses/Necessary Contact Lenses</b> You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at <a href="http://myuhevision.com">myuhevision.com</a> .	\$25 co-pay. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
<b>Low Vision Care Services</b> Limited to once every 24 months.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.	25% co-insurance for Low Vision Testing, after the medical deductible has been met. 25% co-insurance for Low Vision Therapy, 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.**

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- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

**For Internal Use only:**

**NCWAB02BH3919**

**Item#          Rev. Date**

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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](mailto: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 LUU 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 معرف 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)**, udostępniłmy 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. لطفاً 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, 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:** បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) ស្រវឹងនិយាយភាសាដើមឥតគិតថ្លៃ គឺមានស្តាប់អ្នក។ សមនូវសព្វទៅលើខតតគិតថ្លៃ 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.

**DÍI BAA'ÁKONÍNÍZIN:** **Diné (Navajo)** bizaad bee yániti'go, saad bee áka'anida'awo'ígíí, t'áá jíik'eh, bee ná'ahóot'i'. T'áá shqoqí ninaaltsoos nit'i'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.