United Healthcare

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Welcome

Explore the ways your health plan is designed to help you take better care of yourself

United Healthcare

Thank you for being a member

We're here to help make each step of your health care experience easier. Take a look at this guide to help you better understand your benefits, find care options, manage costs and get more out of your health plan—and start experiencing all that care can do for you.

Call toll-free

If you don't have computer access, need language assistance or still have questions after reading this, please call the toll-free member phone number on your health plan ID card.

Connect with us

- Facebook.com/UnitedHealthcare
- Twitter.com/UHC
- Instagram.com/UnitedHealthcare
- YouTube.com/UnitedHealthcare

It's easier to connect to your plan

Your benefits include personalized digital tools that help you check in on your plan whenever you want—which helps make it easier to stay on top of your benefit details.

Activate your myuhc.com account

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

- Find and estimate the cost of care
- See what is covered under your plan
- View claim details
- Check your plan balances
- Find network providers

Get started today:

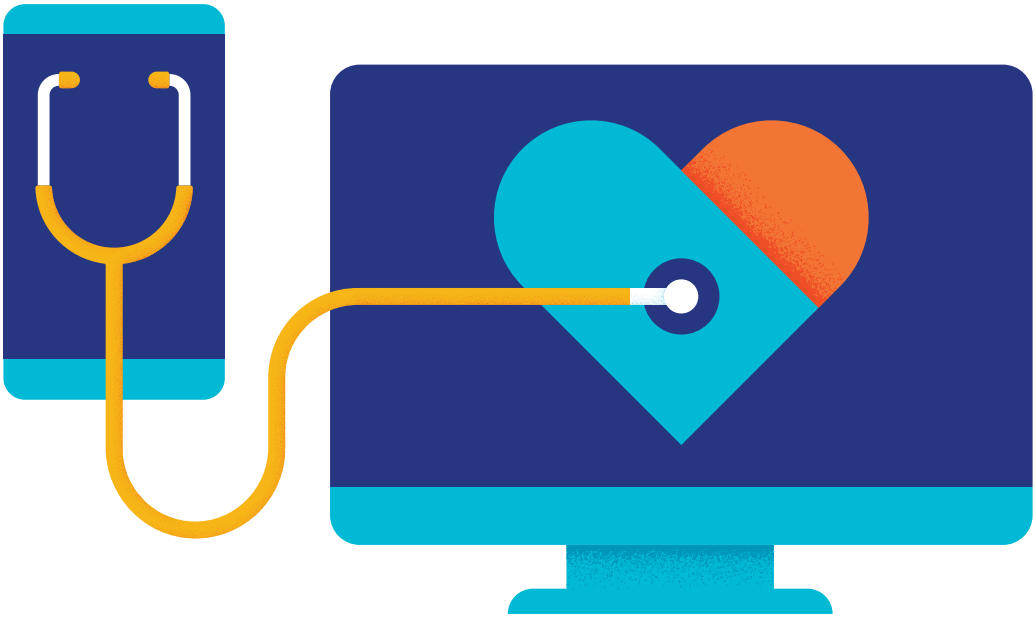
- Go to **myuhc.com > Register Now**
- Have your ID card handy and follow the step-by-step instructions

Download the UnitedHealthcare app

The UnitedHealthcare® app puts your health plan at your fingertips. Download it to:

- Find nearby care options in your network
- See your claim details and view progress toward your deductible
- View and share your health plan ID card with your doctor's office
- Video chat with a doctor 24/7

Download on the App Store | GET IT ON Google Play



Simple ways to help you save

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

Stay in the network

The doctors and facilities in the network may have agreed to provide services at a discount—so visiting an out-of-network provider could end up costing you more for care or may not be covered at all.
Sign in to **myuhc.com > Find Care & Costs** to locate:

- Labs
- Hospitals
- Mental health professionals
- Network providers

Look up the cost of medication

Sign in to **myuhc.com > Pharmacies & Prescriptions** to find information about your medication, pricing and lower-cost options.

Use a Designated Diagnostic Provider

For outpatient laboratory or imaging services—including blood draws/glucose tests, metabolic tests, rapid strep tests, MRI/MRAs and CT, PET or nuclear medicine scans—using a Designated Diagnostic Provider (DDP) may help you save money. DDP laboratory and imaging locations are outpatient hospitals and freestanding imaging centers that have met certain quality and efficiency requirements to earn this designation. Ask your doctor for the lab or imaging order to schedule an appointment at a DDP location. Find one at **myuhc.com > Find Care & Costs**.

Shop around

With such a wide variety of services, from minor procedures to major surgeries, it's a good idea to check approximate pricing first. Visit **myuhc.com > Find Care & Costs** to estimate your costs.

With a PCP, there's a doctor in your corner

A PCP is a primary care provider, sometimes called a primary care physician. They are the doctor who can help connect you to the care you need—and help you avoid cost surprises. A PCP can be a family practitioner, internist, pediatrician or general medicine physician.* Although your plan may not require you and each covered family member to select a network PCP,** it can be a good idea to have one.

Your PCP:

Generally knows your health history and health goals

Provides routine care, which may help identify potential health issues earlier

Advises you when to see a specialist and provides electronic referrals

*Laws in some states allow you to choose a specialist, like an OB/GYN, as your PCP.
**Depending on your health plan, selection of a PCP may be required.

Keep up on preventive care

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

Find a network provider

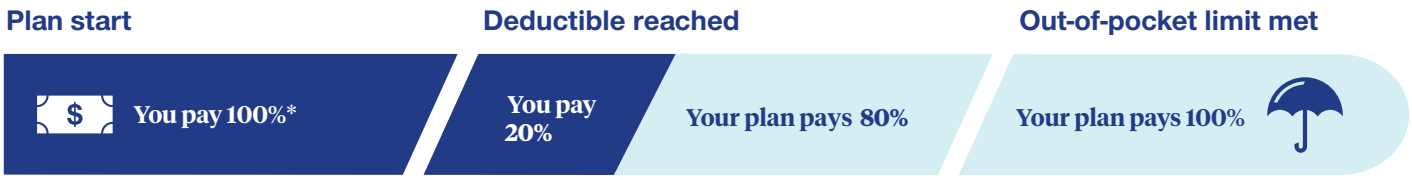
Sign in to **myuhc.com > Find Care & Costs** to find a network PCP, clinic, hospital or lab based on location, specialty, availability, hours of operation and more. You can even see patient ratings and estimate the cost of care before you choose a provider. If you would like more information about a provider's qualifications, call the member phone number on your ID card.

Choose a doctor

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

Here's an example of how a typical health plan works

Let's take a look at an example of how a typical plan works when you receive care from a network provider. Your plan may be different than this example, so to find your specific details go to **myuhc.com > Coverage & Benefits.**



At the start of your plan year, you pay 100% of your covered health services until you meet your **deductible**, which is the amount you pay before your plan starts sharing costs.

Now, your health plan starts to share a percentage of the costs with you —this is your **coinsurance.***

Here, your plan's got you covered at 100%. Your **out-of-pocket limit** is the most you could pay for covered services in a plan year —copays and coinsurance count toward this.

Along the way, you may also be required to pay a fixed amount—or **copay**—each time you see a provider.

*Your deductible and coinsurance may vary by plan or service. This example is for illustrative purposes only. Please refer to your official plan documents for coverage details.

Here's what to do if you need:

Hospital care

Talk to your PCP first to determine which hospital in your network can meet your medical or surgical needs. You or the admitting physician may be required to notify us before you're admitted.

Prior authorization

Your plan may also require prior authorization, sometimes called preauthorization, before you receive certain services. Call the member phone number on your ID card <or sign in at **myuhc.com > Coverage & Benefits**> to check if prior authorization is needed.

No referrals needed

If you need to see a specialist, you don't need to get a referral from your PCP.

Get to know your care options and costs

How much you pay for care can depend on where you get it. For serious or life-threatening conditions, call 911 or go to an emergency room. For everything else, it may be best to contact your PCP first. If seeing your PCP isn't possible, it's important to know your other care options, especially before heading to the emergency room.

Care options to consider and approximate costs	START HERE **PCP** Care from the doctor who may know you best	**24/7 Virtual Visits** See a doctor whenever, wherever	**Urgent care** Serious conditions that aren't generally life-threatening	**Emergency room** Life- and limb-threatening emergencies
Average cost*	**$165**	**Less than $49****	**$185**	**$2,500**
Hours	**Varies by location**	**24/7**	**Varies by location—may be open nights/weekends**	**24/7**
How to connect	**Contact your PCP**	**myuhc.com/virtualvisits**	**myuhc.com**	**myuhc.com**
✔ **indicates the recommended place for care for the following common conditions:**				
Broken bone			✔	✔
Chest pain				✔
Cough	✔	✔		
Fever	✔	✔		
Muscle strain	✔			
Pinkeye	✔	✔		
Shortness of breath				✔
Sinus problems	✔	✔		
Sore throat	✔	✔		
Sprain	✔		✔	
Urinary tract infection	✔	✔		

Need to find a network provider or PCP?

Visiting an out-of-network provider could end up costing you more for care. To find a PCP, urgent care centers and emergency rooms in your network, go to **myuhc.com**.

Not sure where to go for care? Call the number on your health plan ID card.

*Source 2020: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated $2,315 difference between the average emergency room visit, $2,500 and the average urgent care visit $185.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

**The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

Check your official health plan documents to see what services and providers are covered by your plan.

If you have vision benefits

Your vision plan includes:

- A fully covered eye exam—a copay may apply
- Coverage for a second eye exam for your child (up to age 13) each plan year at no additional cost
- A frame allowance to help buy any frame your doctor offers*
- A contact lens benefit to help buy any contact lenses your doctor prescribes
- A contact lens fitting and up to 2 follow-up visits*

There's a provider in sight

Our large provider network includes ophthalmologists and optometrists in private practice and retail settings. To find a network eye doctor and to see what's covered, go to **myuhc.com** or call Vision Customer Care at **1-800-638-3120,** 7 a.m.–10 p.m. CT, Monday–Friday.

*Plans may vary. Review your vision plan documents on myuhc.com to see your specific coverage and cost details.

If you have dental benefits

Your dental plan includes:

- Coverage for all or most of your preventive dental care—including routine checkups, cleanings and annual oral cancer screenings for adults—as long as you see a network dentist
- Two cleanings in a 12-month period (one every 6 months), and some plans cover more cleanings for an additional copay
- Extra visits for cleanings and gum treatments during pregnancy and 3 months following delivery, as recommended by your dentist*

To find a network dentist, see what's covered and use the dental cost calculator,** sign in to **myuhc.com** or call the member phone number on your dental ID card.

Note: Your dental ID card is mailed separately from your health plan ID card. It only lists the name of the person who signed up for the plan, but everyone covered by your plan should bring it to each dental visit.

*Not available in the state of Washington.

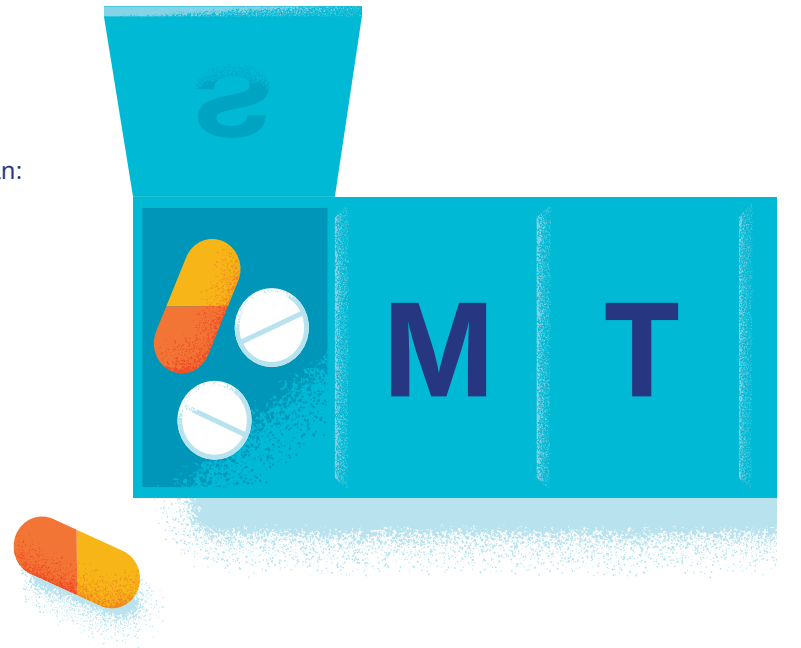
**Not available to members in a SelectManaged Care or DHMO plan.

Get a copy of your vision and dental ID cards, anytime

View, print or share your ID cards by signing in to **myuhc.com.**

Say hello to Optum Rx

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



Manage your meds

When you go to **myuhc.com** > **Pharmacies & Prescriptions** you can:

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

Two ways to fill your prescriptions

Use home delivery

Order up to a 3-month supply of medications you take regularly.* Sign up on **myuhc.com,** use the UnitedHealthcare app or call the member phone number on your ID card. Make sure you have at least a 1-month supply to cover you through the transition.

*Not all prescriptions are eligible for home delivery.

Pick up at the pharmacy

Show your ID card at any network pharmacy—which can be found by checking the Pharmacy Locator at **myuhc.com**, on the UnitedHealthcare app or by calling the member phone number on your ID card.

Keep costs in check

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

Health and wellness benefits powered by care

As part of your health plan benefits, you can sign up for wellness programs and health support services at no additional cost to you. Here's what your plan offers.

24/7 Virtual Visits

Get care, virtually anywhere

With 24/7 Virtual Visits, you can connect to a care provider by phone or video* through **myuhc.com** or the UnitedHealthcare app. Providers can treat a wide range of nonemergency health conditions—from flu and pinkeye to migraines and more—and may even prescribe medication as needed.** Get started at **myuhc.com/virtualvisits** or via the UnitedHealthcare app.

*Data rates may apply.

**Certain prescriptions may not be available, and other restrictions may apply.

Behavioral Support

Tap into behavioral health support

Get connected to self-help digital tools, in-person or virtual behavioral health providers and other resources that may help with a variety of concerns, such as depression and anxiety, relationship difficulties, grief and loss, alcohol and drug use, compulsive habits, eating disorders and more. Call the member phone number on your ID card or visit **myuhc.com.**

Employee Assistance Program

It helps to have someone to talk to

When life gets stressful, the Employee Assistance Program (EAP) is just a phone call away. EAP coordinators are available 24/7 for confidential conversation and referrals to expert care and services to help with personal or work-related challenges—from helping you address depression, stress, anxiety or substance use issues to finding support for child and elder care services and more. Call the member phone number on your ID card or learn more at **www.uhc.com/eap**.

Rally

Rewards for well-being

Have fun and get healthier with Rally®. Take a health survey to see how you're doing in key areas like nutrition, fitness and stress, get personalized recommendations that fit your lifestyle, track your progress on your dashboard and earn Rally Coins that can be redeemed for rewards. Get started at **myuhc.com.**

SimplyEngaged

Rewards for healthier actions

Get connected to personalized health recommendations with SimplyEngaged®. This online experience includes health and wellness coaching, content and resources—and you may earn rewards* for completing certain health and wellness activities. Get started at **myuhc.com.**

*There is a maximum associated with these rewards. Employees and covered spouses can earn rewards separately. Children may not participate in the reward program. Incentives can be earned only once every plan year.

Real Appeal

Lose weight, feel great

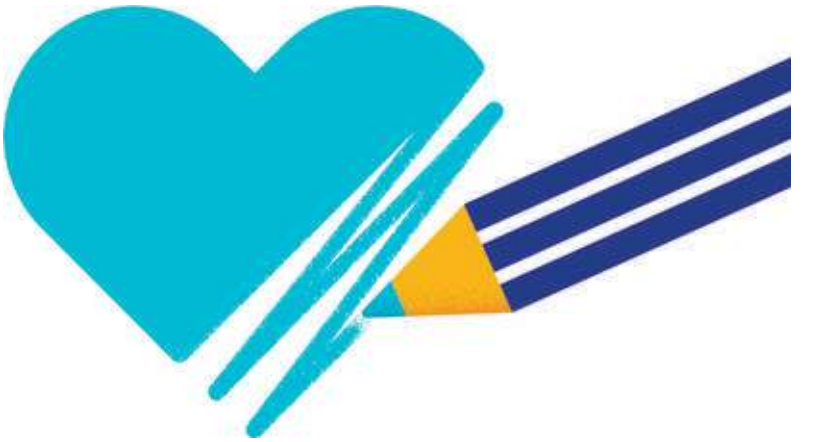
Connect with a community of support with Real Appeal®, an online weight loss program designed to inspire healthier behaviors. It includes group coaching sessions, 24/7 online resources, a mobile app to set and track goal progress and a Success Kit with scales, exercise tools, food guides and more delivered to your door. Get started at **myuhc.com.**

Access to Real Appeal not available in Hawaii.

Quit For Life

Quit tobacco for good

With a coach on your side, it may be easier to leave tobacco behind. The Quit For Life® program includes online support, a customized action plan and more to help you go tobacco-free. Enroll today at **myuhc.com.**



Here's the fine print

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

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Mail: UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Online: UHC_Civil_Rights@uhc.com

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 member phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services:

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201

We provide free services to help you communicate with us such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

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.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.

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, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

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

Visit www.uhc.com/legal/required-state-notices to view important state required notices.

Member phone number services should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the member phone number services are for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Your health information is kept confidential in accordance with the law. Member phone number services are not an insurance program and may be discontinued at any time.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Evaluation of New Technologies: UnitedHealthcare's Medical Technology Assessment Committee reviews clinical evidence that impacts the determination of whether new technology and health services will be covered. The Medical Technology Assessment Committee is composed of Medical Directors with diverse specialties and subspecialties from throughout UnitedHealthcare and its affiliated companies, guest subject matter experts when required, and staff from various relevant areas within UnitedHealthcare. The Committee meets monthly to review published clinical evidence, information from government regulatory agencies and nationally accepted clinical position statements for new and existing medical technologies and treatments, to assist UnitedHealthcare in making informed coverage decisions.

The information in this guide is a general description of your coverage. It is not a contract and does not replace the official benefit coverage documents which may include a Summary of Benefits and Coverage and Certificate of Coverage/Summary Plan Description. If descriptions, percentages, and dollar amounts in this guide differ from what is in the official benefit coverage documents, the official benefits coverage documents prevail.

Twitter is a registered trademark of Twitter, Inc. Facebook is a registered trademark of Facebook, Inc. YouTube is a registered trademark of Google, Inc. Instagram is a registered trademark of Instagram, LLC.

The UnitedHealthcare® app is available for download for iPhone® or Android®.

Android is a registered trademark of Google LLC.

Google Play and the Google Play logo are registered trademarks of Google Inc.

Apple, App Store and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries.

All UnitedHealthcare members can access a cost estimate online or on thea mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Cost and Care section. Refer to your health plan coverage documents for information regarding your specific benefits.

Optum Rx® is an affiliate of UnitedHealthcare Insurance Company.

Plans may vary. Please review your vision plan documents to view the plan's specific coverage and cost details. Not all providers participate in all plans. Check with your provider before using your benefits. Warby Parker added to the network effective January 2018. Network location count as of Oct. 1, 2017. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of coverage, contact UnitedHealthcare Insurance Company. UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

UnitedHealthcare dental coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), DBP Services (NY only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX, DPOL.12.TX and DPOL.12.TX (Rev. 9/16) and associated COC form numbers DCOC.CER.06, DCOC.CER.IND.12.TX and DCERT.IND.12.TX. Plans sold in Virginia use policy form number DPOL.06.VA with associated COC form number DCOC.CER.06.VA and policy form number DPOL.12.VA with associated COC form number DCOC.CER.12.VA.

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. **Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. You should also discuss designations with a physician before choosing him or her. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician.** Please visit myuhc.com for detailed program information and methodologies.

The material provided through the Employee Assistance Program (EAP) is for informational purposes only. EAP staff cannot diagnose problems or suggest treatment. EAP is not a substitute for your doctor's care. Employees are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. EAP is not an insurance program and may be discontinued at any time. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

The Quit For Life® Program provides information regarding tobacco cessation methods and related well-being support. Any health information provided by you is kept confidential in accordance with the law. The Quit For Life Program does not provide clinical treatment or medical services and should not be considered a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Participation in this program is voluntary. If you have specific health care needs or questions, consult an appropriate health care professional. This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.

Rally® Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Real Appeal is a voluntary weight loss program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

SimplyEngaged® is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional to determine what may be right for you. Rewards may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from receiving rewards under this program. If you are unable to meet a standard related to a health factor to obtain a reward under this program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-855-215-0230 and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward.

24/7 Virtual Visits is a service available with a provider via video, or audio-only where permitted under state law. It is not an insurance product or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

United Healthcare

Choice Plus plan details, all in one place.

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

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☑

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

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

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$3,500	$7,500
Family	$7,000	$15,000

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

**After the Annual Medical Deductible has been met.*

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

Annual Out-of-Pocket Limit		
Individual	$6,350	$12,700
Family	$12,700	$25,400

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

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	20%*
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 copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons		$30 copay*	20%*
Covered persons less than age 19		No copay*	20%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.			
Telehealth is covered at the same cost share as in the office.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$60 copay*	20%*
Urgent Care Center Services *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*		$100 copay*	20%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay*	20%*
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		No copay*	No copay*
Ground Ambulance		No copay*	No copay*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance		No copay*	No copay*
Ground Ambulance		No copay*	20%*
Dental Services - Accident Only		No copay*	No copay*
Emergency Health Care Services - Outpatient[1]		$350 copay*	$350 copay*
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]		No copay*	20%*
Habilitative Services - Inpatient[1] *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.		
Hospital - Inpatient Stay[1]		No copay*	20%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 30 days per year in a Skilled Nursing Facility.* *Limited to 60 days per year in an Inpatient Rehabilitation Facility.* *Limits for Skilled Nursing Facility is per inpatient stay.*		No copay*	20%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Outpatient Care			
Habilitative Services - Outpatient			
Manipulative Treatment		$30 copay*	20%*
Other habilitative services		$30 copay*	20%*
Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.			
Home Health Care[1]		No copay*	20%*
Limited to 60 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.			
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1]	No copay*	50%*	20%*
Limited to 18 Definitive Drug Tests per year.			
Limited to 18 Presumptive Drug Tests per year.			
For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.			
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		No copay*	20%*
Major Diagnostic and Imaging - Outpatient[1]	No copay*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%*
For Designated Network Benefits, services must be received from a Designated Diagnostic Provider. Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.			
You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.			
Physician Fees for Surgical and Medical Services		No copay*	20%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Manipulative Treatment		$30 copay*	20%*
Other rehabilitation services		$30 copay*	20%*
Limited to 20 visits of cognitive rehabilitation therapy per year.			
Limited to 20 visits of occupational therapy per year.			
Limited to 20 visits of physical therapy per year.			
Limited to 20 visits of pulmonary rehabilitation therapy per year.			
Limited to 20 visits of speech therapy per year.			
Limited to 30 visits of post-cochlear implant aural therapy per year.			
Limited to 36 visits of cardiac rehabilitation therapy per year.			
Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.			
Scopic Procedures - Outpatient Diagnostic and Therapeutic		No copay*	20%*
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.			
Surgery - Outpatient[1]		No copay*	20%*
Therapeutic Treatments - Outpatient[1]		No copay*	20%*
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.			
Supplies and Services			
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies[1]		No copay*	20%*
Limited to 1 insulin pump per year.			
Limited to a single purchase of a type of DME or orthotic every 3 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.			
Enteral Nutrition		No copay*	20%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Hearing Aids *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		No copay*	20%*
Ostomy Supplies		No copay*	20%*
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*		No copay*	20%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every 3 years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*		No copay*	20%*
Urinary Catheters		No copay*	20%*
Pregnancy			
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		No copay*	20%*
Outpatient and Transitional Care[1]		No copay*	20%*
Partial Hospitalization and Transitional Care[1]		No copay*	20%*
Other Services			
Autism Spectrum Disorder Services[1]	The amount you pay is based on where the covered health care service is provided.		
Cellular and Gene Therapy[1] *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.		
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Dental/Anesthesia Services – Hospital Ambulatory Surgery Services[1]	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*		No copay*	20%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care[1]		No copay*	20%*
Kidney Disease Treatment[1]	The amount you pay is based on where the covered health care service is provided.		
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.* *Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.*		No copay*	20%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Temporomandibular Joint (TMJ) Disorder Services[1]	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		Not covered

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage
	In Network
Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section

Annual Deductible - Network and Out-of-Network

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	**Out-of-Network Pharmacy**	**Mail Order Network Pharmacy****
Tier 1 $	$10*	$10*	$25*
Tier 2 $$	$35*	$35*	$87.50*
Tier 3 $$$	$70*	$70*	$175*

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

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

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

For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to **welcometouhc.com > Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to **welcometouhc.com > Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With **myuhc.com®,** you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.

Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

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

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product.

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

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

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

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

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

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

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

Other important information about your benefits.

Pharmacy Exclusions

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

- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications. This exclusion does not apply to Prescription Drug Products that are prescribed by a Physician for the treatment of HIV infection, illness or medical condition arising from or related to HIV infection, if the medication is approved by the FDA and prescribed and administered in accordance with the treatment protocol approved for an Investigational new drug.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Medications used for cosmetic purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

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

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

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

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

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.

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

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

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

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

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

UnitedHealthcare®

Choice Plus plan details, all in one place.

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

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

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

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

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$2,000	$5,000
Family	$4,000	$10,000

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

**After the Annual Medical Deductible has been met.*

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

Annual Out-of-Pocket Limit		
Individual	$7,150	$10,000
Family	$14,300	$20,000

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

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	50%*
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 copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons	$15 copay	$15 copay	50%*
Covered persons less than age 19	No copay	No copay	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.			
Telehealth is covered at the same cost share as in the office.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	$50 copay	$100 copay	50%*
Urgent Care Center Services *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*		$25 copay	50%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay	50%*
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	20%*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	50%*
Dental Services - Accident Only		20%*	20%*
Emergency Health Care Services - Outpatient[1]		You pay a $300 per occurrence deductible per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%*	You pay a $300 per occurrence deductible per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%*
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]		20%*	50%*
Habilitative Services - Inpatient[1] *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.		
Hospital - Inpatient Stay[1]		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 30 days per year in a Skilled Nursing Facility.* *Limited to 60 days per year in an Inpatient Rehabilitation Facility.* *Limits for Skilled Nursing Facility is per inpatient stay.*		20%*	50%*
Outpatient Care			
Habilitative Services - Outpatient			
Manipulative Treatment		$15 copay	50%*
Other habilitative services *Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*		$15 copay	50%*
Home Health Care[1] *Limited to 60 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.*		20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1] *Limited to 18 Definitive Drug Tests per year.* *Limited to 18 Presumptive Drug Tests per year.* *For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.*	20%*	50%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		20%*	50%*
Major Diagnostic and Imaging - Outpatient[1] *For Designated Network Benefits, services must be received from a Designated Diagnostic Provider. Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.* *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	20%*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Physician Fees for Surgical and Medical Services			
Primary care visits	20%*	20%*	50%*
Specialist care visits	20%*	20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Manipulative Treatment		$15 copay	50%*
Other rehabilitation services		$15 copay	50%*
Limited to 20 visits of cognitive rehabilitation therapy per year.			
Limited to 20 visits of occupational therapy per year.			
Limited to 20 visits of physical therapy per year.			
Limited to 20 visits of pulmonary rehabilitation therapy per year.			
Limited to 20 visits of speech therapy per year.			
Limited to 30 visits of post-cochlear implant aural therapy per year.			
Limited to 36 visits of cardiac rehabilitation therapy per year.			
Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.			
Scopic Procedures - Outpatient Diagnostic and Therapeutic		20%*	50%*
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.			
Surgery - Outpatient[1]		20%*	50%*
Therapeutic Treatments - Outpatient[1]		20%*	50%*
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.			
Supplies and Services			
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies[1]		20%*	50%*
Limited to 1 insulin pump per year.			
Limited to a single purchase of a type of DME or orthotic every 3 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.			
Enteral Nutrition		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Hearing Aids *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		20%*	50%*
Ostomy Supplies		20%*	50%*
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*		20%*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every 3 years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*		20%*	50%*
Urinary Catheters		20%*	50%*
Pregnancy			
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		20%*	50%*
Outpatient and Transitional Care[1]		$15 copay	50%*
Partial Hospitalization and Transitional Care[1]		20%*	50%*
Other Services			
Autism Spectrum Disorder Services[1]	The amount you pay is based on where the covered health care service is provided.		
Cellular and Gene Therapy[1] *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.		
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Dental/Anesthesia Services – Hospital Ambulatory Surgery Services[1]	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*		20%*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care[1]		20%*	50%*
Kidney Disease Treatment[1]	The amount you pay is based on where the covered health care service is provided.		
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.* *Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.*		20%*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Temporomandibular Joint (TMJ) Disorder Services[1]	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		Not covered

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

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

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 $	$15	$15	$45
Tier 2 $$	$45	$45	$135
Tier 3 $$$	$85	$85	$255
Tier 4 $$$$	$200	$200	$600

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

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4.

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

For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to **welcometouhc.com > Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to **welcometouhc.com > Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With **myuhc.com®,** you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.

Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

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

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product.

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

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

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

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

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

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

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

Other important information about your benefits.

Pharmacy Exclusions

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

- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications. This exclusion does not apply to Prescription Drug Products that are prescribed by a Physician for the treatment of HIV infection, illness or medical condition arising from or related to HIV infection, if the medication is approved by the FDA and prescribed and administered in accordance with the treatment protocol approved for an Investigational new drug.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Medications used for cosmetic purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

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

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

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

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

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.

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

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

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

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

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

UnitedHealthcare®

Vision Benefit Summary

Powered by UnitedHealthcare Vision Network

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

Plan SH107

UnitedHealthcare Vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for persons with diabetes	Twice every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses instead of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Eyeglasses (lenses and frame)	$ 25.00
Contact lenses instead of Eyeglasses	$ 25.00
Retinal Screening for persons with diabetes	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$150.00 retail frame allowance
Retail Chain Provider	$150.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full.	
Contact Lens Benefit[2]	
Elective contact lenses Allowance is applied toward the purchase of contact lenses. Contact lens copay is waived.	$150.00
Elective contact lens fitting and evaluation Allowance is applied toward the contact lens fitting/evaluation fees.	$40.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Children's and Maternity Eye Care Benefit	
Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam 60 days after the initial exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.	
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal and Progressive Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts instead of Eyeglasses[2]	Up to $125.00
Contact Lens Fitting and Evaluation	Up to $0.00
Necessary Contacts instead of Eyeglasses[3]	Up to $210.00

UnitedHealthcare

Discounts	
	Laser vision UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Contact Lens Order extra contact lenses at uhccontacts.com for 10% off.
	Hearing Aids As a UnitedHealthcare Vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.
	Blue Light Eyesafe UnitedHealthcare Vision has collaborated with Eyesafe® to provide members with a 20% discount off the retail price on blue-light screen filters for their devices. Members can receive the discount by visiting myuhcvision.com and clicking on the Eyesafe link.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are instead of eyeglass lenses and/or eyeglass frames.
[3]Necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare Vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Patient lens options which are not covered-in-full may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

READ YOUR PLAN CAREFULLY - THIS BENEFIT SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

UnitedHealthcare®

UnitedHealthcare®
Consumer MaxMultiplier Voluntary National Options PPO 30

FlexAppeal P&D dental plan
H7088 /UCR90

Network/covered dental services

	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150	$150
Annual Maximum Benefit* *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1500 per person per Calendar Year	$1500 per person per Calendar Year
Annual Deductible and Annual Maximum Benefit Applies to Preventive and Diagnostic Services	No	
Waiting Period	No waiting period	

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

* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

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

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

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

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

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.
UnitedHealthcare Dental® Voluntary Options PPO Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United Healthcare Services, Inc.

UnitedHealthcare/dental exclusions and limitations

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

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

GENERAL LIMITATIONS

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

GENERAL EXCLUSIONS

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

GENERAL EXCLUSIONS

21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
23. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to tl date individual Coverage under the Policy terminates.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic Services.
26. In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
27. Foreign Services are not Covered unless required as an Emergency.
28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
29. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

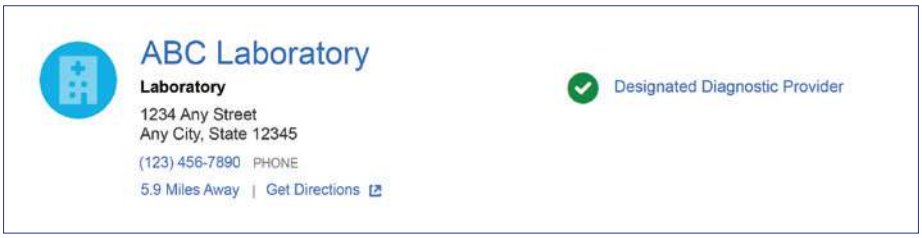
Say hello to the Designated Diagnostic Provider benefit

Designated Diagnostic Providers (DDP) are laboratory and imaging services providers that meet certain quality and efficiency requirements. With your DDP benefit, you'll have the highest level of coverage—and likely save money—when you use a DDP for outpatient lab and imaging services. If you don't use a DDP, your lab and imaging services may not be covered, and you may be responsible for 100% of the cost.

Just look for the green check

To find a lower-cost DDP near you, go to **myuhc.com® > Find Care & Costs > Medical Directory > Places**.

Choose whether you'd like lab or imaging services and then look for the green check to confirm DDP status. For DDP imaging services, just make your appointment. For DDP lab work, just be sure to tell your doctor which DDP to use.



DDP outpatient lab and imaging services

Using a DDP may help you save money on many services, including:

Lab services

- Blood draws
- Blood glucose tests
- Metabolic tests/panels
- Rapid strep tests

Imaging services

- CT and PET scans
- MRI/MRAs
- Nuclear medicine scans

Get started

Find DDPs at **myuhc.com** or on the UnitedHealthcare® app

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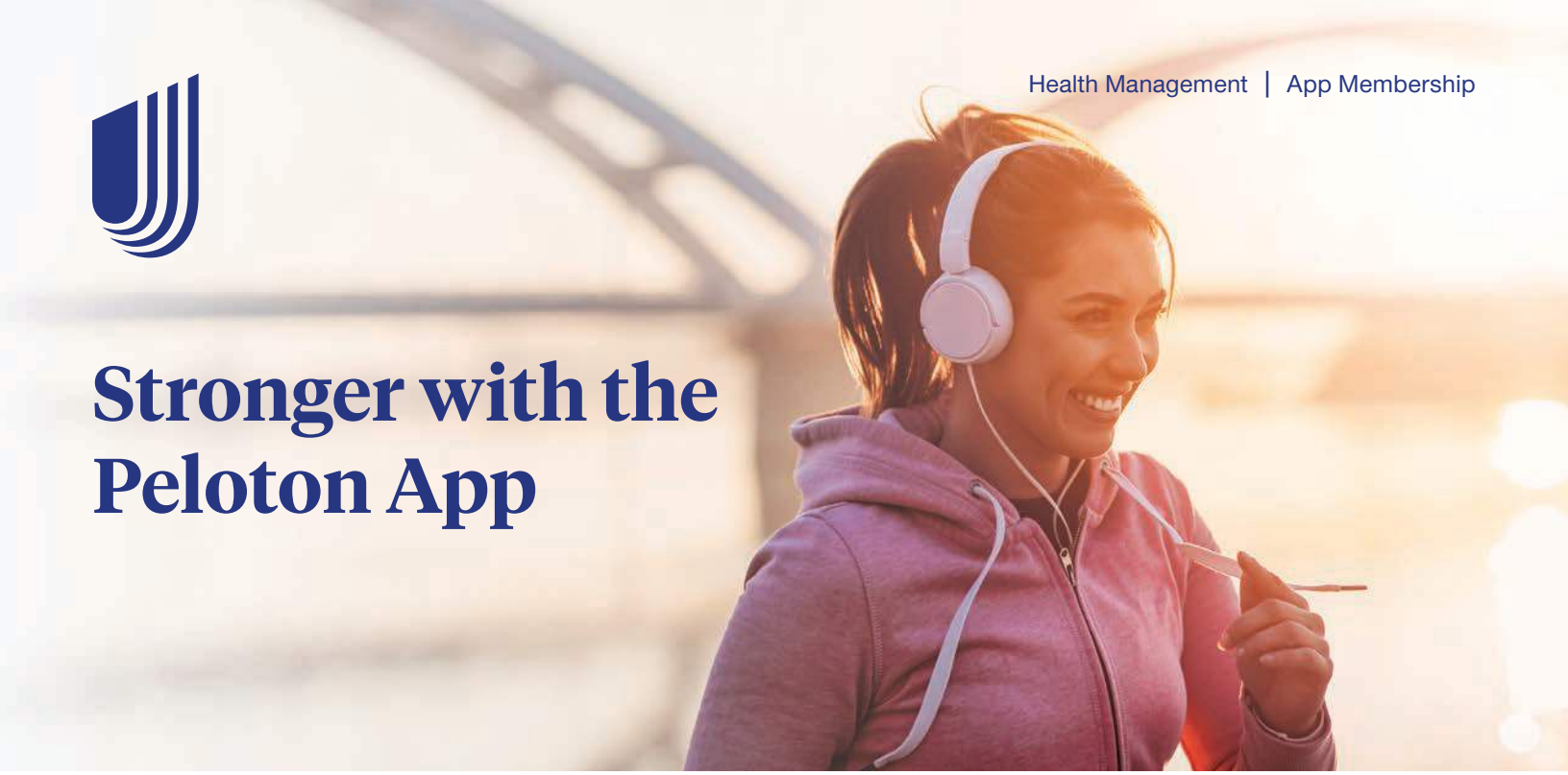


Stronger with the Peloton App

Your health plan benefits include a 1-year Peloton App Membership—available to you at no additional cost. Start your Membership today for access to thousands of live and on-demand fitness classes—from cardio and HIIT to strength training and yoga.

The Peloton App gives you:

Access to thousands of fitness classes
There's something for nearly every fitness interest, ability and schedule — from 5-minute meditation to 60-minute outdoor running classes.

The flexibility to get active anytime, anywhere
The App is available on any iOS or Android device, Apple TV, Fire TV, Roku TVs, and Chromecast and Android TV—and no fitness equipment is required.

Ways to help you have fun and stay motivated
Enjoy the App's many features, training programs and challenges, all designed to help you track your progress and stay motivated.

Get in on the App — a value of $155

You and each covered family member can enjoy this benefit at no additional cost—just for being a UnitedHealthcare member.*

Get started

Sign in to **myuhc.com/peloton** then go to **Coverage & Benefits** to get your access code

continued

United Healthcare | PELOTON

United Healthcare | PELOTON

*For a limited time, the Peloton offering is available to members enrolled in applicable fully insured UnitedHealthcare plans and participants enrolled in UnitedHealthcare Level Funded NavigateNOW, UnitedHealthcare self-funded plans, and UnitedHealthcare Level Funded plans whose employer purchases the offering. Additional details, including offer expiration date are on https://www.myuhc.com/peloton. Members and participants must be 18+ years of age and register for an account with Peloton. Members and participants that own a Peloton Bike, Bike+ or Tread can redeem a 3-month All-Access Membership. Limit one code redemption per member or participant. All services provided by Peloton directly to consumers are governed by Peloton's Membership Terms, located at https://www.onepeloton.com/membershipterms.

The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. The value of the application may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from having access to this application at no additional cost.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by All Savers Insurance Company (except CA, MA, MN, NJ and NY), UnitedHealthcare Insurance Company in MA and MN, UnitedHealthcare Life Insurance Company in NJ, UnitedHealthcare Insurance Company of New York in NY, and All Savers Life Insurance Company of California in CA.

Make your move with Apple Fitness+

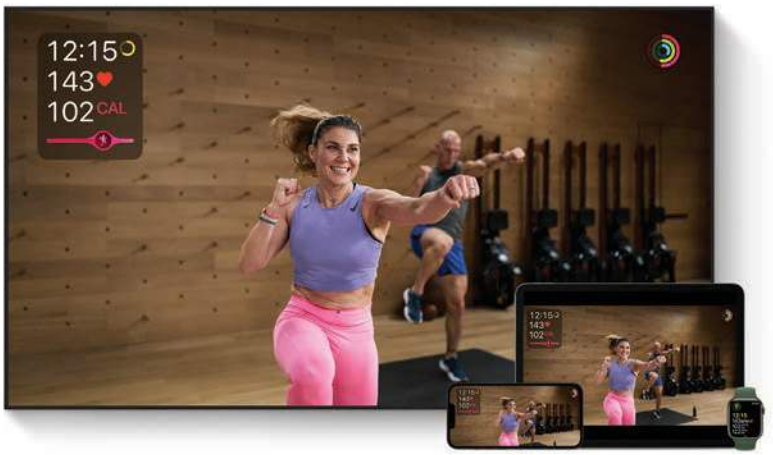
Now included in your health plan

UnitedHealthcare is committed to providing a variety of health and wellness options, which is why we've added 12 months of Apple Fitness+ to your health plan—at no additional cost. Get ready for a different type of fitness experience with welcoming trainers who work hard to help bring out the best in you.

The first fitness service powered by Apple Watch

Your journey to a healthier body and mind starts here. Apple Fitness+ brings to life real-time fitness metrics from Apple Watch to your iPhone, iPad and Apple TV—and helps keep you motivated with:

- 11 workout types, ranging from HIIT to Pilates to strength to yoga
- New workouts and meditations added every week, lasting from 5 to 45 minutes
- Handpicked music from your favorite artists to help keep you going
- A subscription that can be shared with up to 5 family members



No additional cost

A $79.99 value*

(Apple Watch required)

Let's do this

Get started at **uhc.com/apple-fitness-plus**

United Healthcare | Fitness+

*$9.99 per month for 12 months or $79.99 annually. Must be 13+ years of age and covered under applicable health plan.

Apple Fitness+ requires Apple Watch Series 3 or later with watchOS 7.2 or later and one of the following Apple devices: iPhone 6s or later with iOS 14.3 or later, iPad with iPadOS 14.3 or later, or Apple TV with tvOS 14.3 or later. Available to applicable UnitedHealthcare plans for fully insured and level funded members who register for an account with Apple Fitness+.

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Earn up to $240* for completing health and wellness activities.

With SimplyEngaged, you can get rewarded for taking healthier actions.

Here's how SimplyEngaged works.

Through Rally®, you can access the SimplyEngaged® health and wellness activities available to you. For each Health Action you complete, you'll earn Rally Coins,** which you can redeem for rewards. Plus, you can earn financial incentives provided through a bank account deposit. Rally's digital experience gives you one place to track your activities and rewards.

To get started, go to **myuhc.com® > Health Resources > Rally.**

Health Actions	Reward
Complete the Health Survey and watch the video. The Health Survey takes about 15 minutes and upon completion, you'll receive personalized suggestions to help you set health goals. Pair this with a short Health Actions video to see your opportunities to earn rewards.	Rally Coins
Complete a Virtual Visit. Virtual Visits may be a convenient option when you need care. You can talk to a doctor—24/7—by phone or video for conditions like the flu, allergies, rashes, migraines and many more.	Rally Coins

*Earnings are per person and include covered spouse or domestic partner.

**Rally Coins can be earned under Rally Health. A reward can only be earned once per incentive year per health action, with the exception of the Fitness Action, up to the maximum incentive amount. Rally Coins may be used to enter sweepstakes for additional rewards.

continued

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Health Actions	Reward
Complete a coaching program. The results of your Health Survey will provide recommendations for coaching programs that may help improve your health and wellness. These programs are available at no additional cost as part of your health plan benefits. Complete one of the following programs to earn more rewards: **Wellness Coaching** provides access to expert coaches and digital tools to help you reach your health goals. It's all about getting and staying healthy—your way—anytime. Choose from a variety of programs, like sleeping better, eating smarter and getting fit. **Real Appeal®** may help you start living a healthier life with online weight loss tools designed to help you achieve lifelong results, one small step at a time. Real Appeal provides the support to help you lose weight through online coaching, a Success Kit delivered to your door and a community of members to keep you motivated. **Quit For Life®** has helped 4 million enrollees quit smoking or using tobacco.[1] It provides the tools, 1-on-1 support and a personalized plan to help you quit your way.	**Rally Coins**
Complete a Gym Check-in. Check in to a participating fitness center at least 12 days per month on the Rally Health app. Select from a network of leading fitness centers, where you'll find boxing, climbing, cycling, yoga, Pilates, traditional gyms and more.	**$20/mo.+ Rally Coins**

myuhc.com > Health Resources > Rally

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[1] Quit For Life Employer Book of Business Survey results, cumulative from 2006 to 2018.

Real Appeal is a voluntary weight loss program that is offered to eligible participants as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

The Quit For Life Program provides information regarding tobacco cessation methods and related well-being support. Any health information provided by you is kept confidential in accordance with the law. The Quit For Life Program does not provide clinical treatment or medical services and should not be considered a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Participation in this program is voluntary. If you have specific health care needs or questions, consult an appropriate health care professional. This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.

UnitedHealthcare understands the importance of protecting your privacy. We care about the relationship we have with you. Our business practices are in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security requirements.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the Health Survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

SimplyEngaged® is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional to determine what may be right for you. Rewards may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from receiving rewards under this program. If you are unable to meet a standard related to a health factor to obtain a reward under this program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-855-215-0230 and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

With our large vision network, there's always a provider in sight

Finding a trustworthy provider who meets your lifestyle, eye care and eyewear needs is easier with UnitedHealthcare.

With our large national eye care network, UnitedHealthcare Vision Network, you can take advantage of personalized care at a private practice or convenient evening and weekend hours at your favorite retail chain.

Well-known practices and brands in our large national network include:

- **1-800 Contacts**
- 20/20 Vision Center
- 3 Guys Optical
- All About Eyes
- Allegany Optical
- America's Best
- Bard Optical
- **befitting.com**
- Boscov's Optical
- Clarkson Eyecare
- Cohen's Fashion Optical
- Costco Optical
- Crown Vision Center
- Dr. Tavel Family Eye Care
- Eye Boutique
- Eye Care Center
- Eye Doctor's Optical Outlets
- EyeCare Associates
- Eyeglass World
- EyeMart Express
- Eyetique
- For Eyes
- General Vision Services
- **GlassesUSA.com**
- Henry Ford OptimEyes
- Horizon Eye Care
- Houston Eye Associates
- JCPenney Optical
- LensCrafters
- Meijer Optical
- Midwest Vision Centers
- My Eye Lab
- MyEyeDr.
- National Vision
- Nationwide Vision
- Optyx
- Pearle Vision

Making it easier for you to find a provider

To find the provider who best meets your needs, sign in to **myuhcvision.com** or call **1-800-638-3120.**

Some providers or locations may not participate in your plan.

continued

United Healthcare

Well-known practices and brands in our large national network include:

- Rosin Eyecare
- Rx Optical
- Sam's Club
- SEE Inc.
- Shawnee Optical
- Shopko
- Site for Sore Eyes
- Standard Optical
- Stanton Optical
- Sterling Optical
- SVS Vision
- Target Optical
- Texas State Optical
- The Eye Doctors
- The Eye Gallery
- Today's Vision
- Total Vision
- Virginia Eye Institute
- Vision Source
- Vision4Less
- Visionworks
- Vista Optical
- Walmart
- Warby Parker—including **warbyparker.com**
- Wisconsin Vision

See more ways to save

Keep out-of-pocket costs low by visiting **uhccontacts.com** or **uhcglasses.com** where you'll have a variety of brands and frame choices at your fingertips.

Call
1-800-638-3120

Visit
myuhcvision.com

United Healthcare

Get rewarded for taking care of your smile

Our Consumer MaxMultiplier® program rewards you for keeping up with your dental care by adding dollars to next year's annual maximum. It's included as part of your dental plan.

How the program works

Earn award dollars for visiting your dentist at least once a year.[1]

Your award dollars will help to pay for claims that go beyond your annual maximum.

Unused award dollars can roll over each year.

Earn up to

$500

to add to your 1500 annual maximum

Award dollars can add up

Here's an example of the award dollars you could earn if you visit your dentist at least once this year:

This year's annual maximum is	If your total claims are less than	You'll earn a reward of
$1500	$750	$400

Plus, if you have a Dental PPO plan and all claims are with network dentists, you'll earn an extra $100. Your award dollars will be added to next year's annual maximum to pay for qualifying claims. To view your annual maximum balance, log in to myuhc.com®.

continued

United Healthcare

Program rules

1. $1,500 is the most award dollars that can be rolled over to the annual maximum. The total annual maximum cannot go above $3,000.
2. If your plan has different annual network and out-of-network maximums, the award dollars will be based on the annual out-of-network maximum. Award dollars are added to your annual maximum the following year.
3. Award dollars can be used for claims filed up to 180 days after your benefit period ends.
4. Award dollars can be used for both network and out-of-network claims.
5. Award dollars do not apply to orthodontic services.
6. If you sign up for a UnitedHealthcare Dental PPO or Dental In-Network Only (INO) plan in the last 3 months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in this program.
7. If you end your coverage, but sign up again within 6 months with the same employer, you can keep your award balance as long as your employer still offers a dental plan with Consumer MaxMultiplier. If 6 months or more pass, you will lose the award balance.
8. If your employer decides to change your dental plan, your award balance will move with you as long as the new plan includes Consumer MaxMultiplier.

Questions? Call the member phone number on your digital ID card

United Healthcare

* You will not actually earn cash that you can access or withdraw. UnitedHealthcare adds the award dollars to your annual maximum for the following year and applies them to qualifying claims.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter.

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。

This program may not be available in all states. Components subject to change.

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the company.

UnitedHealthcare dental coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), DBP Services (NY only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.98.TX, DPOL.12.TX and DPOL.12.TX (Rev. 9/19) and associated COC form numbers DCOC.CER.98, DCOC/CER/IND.12.TX and DCERT/IND.12.TX. Plans sold in Virginia use policy form number DPOL.98.VA with associated COC form number DCOC. CER.98.VA and policy form number DPOL.12.VA with associated COC form number DCOC.CER.12.VA.