UnitedHealthcare®

Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO SCHEDULE OF BENEFITS

PLATINUM SIGNATURE 0

These services are covered as indicated when authorized through your Primary Care Physician in your Participating Medical Group.

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum[1]	$3,000/individual $6,000/family
PCP/ Other Practitioner Office Visits	$20 Office Visit Copayment
Specialist (Member required to obtain referral to specialist, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	$40 Office Visit Copayment
Hospital Benefits	30% Copayment
Emergency Services (Copayment waived if admitted)	$200 Copayment
Urgently Needed Services	
Urgent care services – services provided **within** the geographic area served by your medical group	$20 Office Visit Copayment
Urgent care services – services provided **outside** of the geographic area served by your medical group	$50 Copayment
Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the geographic area served by your medical group.	

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	30% Copayment
Clinical Trials[2]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	30% Copayment
Hospital Benefits	30% Copayment
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	30% Copayment

Benefits Available While Hospitalized as an Inpatient (Continued)

Maternity Care[6]	30% Copayment
Mental Health Services including, but not limited to, Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	30% Copayment
Newborn Care[3]	30% Copayment
Physician Care	No charge
Reconstructive Surgery	30% Copayment
Rehabilitation and Habilitation Care (Including physical, occupational and speech therapy)	30% Copayment
Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child Inpatient and Residential Treatment Unlimited days **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	30% Copayment
Skilled Nursing Facility Care (Up to 100 days per benefit period)	30% Copayment
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	30% Copayment
Termination of Pregnancy (Medical/medication and surgical)	30% Copayment

Benefits Available on an Outpatient Basis

Acupuncture **Please refer to your Acupuncture Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	$10 Copayment
Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist	 $20 Office Visit Copayment $40 Office Visit Copayment
Ambulance (Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Copayment)	$100 Copayment
Chiropractic Care (20-visit maximum per calendar year) **Please refer to your Chiropractic Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**	$15 Copayment
Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices[4] (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation/habilitation therapy may apply)	$50 Copayment per item

Benefits Available on an Outpatient Basis (Continued)

Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply. Please refer to your Dental Supplement to the Combined Evidence of Coverage and Disclosure Form for pediatric dental benefits.)	$50 Copayment
Dialysis (Physician office visit Copayment may apply)	$50 Copayment per treatment
Durable Medical Equipment[4]	$50 Copayment per item
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19.)	No charge
Family Planning (Non-Preventive Care)[7]	
Vasectomy	$50 Copayment
Depo-Provera Injection – (other than contraception)[7]	
PCP/ Practitioner Office Visit	$20 Office Visit Copayment
Specialist	$40 Office Visit Copayment
Depo-Provera Medication – (other than contraception)[7] (Limited to one Depo-Provera injection every 90 days.)	$35 Copayment
Termination of Pregnancy (Medical/medication and surgical)	30% Copayment
Hearing Aid - Standard ($2,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years.)	$50 Copayment
Hearing Aid - Bone Anchored[6] (Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.)	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits
Hearing Exam[6]	
PCP Office Visit/ Nonphysician Health Care Practitioner Office Visit	$20 Office Visit Copayment
Specialist	$40 Office Visit Copayment
Home Health Care Visits Limited to a maximum of 100 visits per year. Visit limit does not apply to home health visits for rehabilitation and habilitation purposes. Rehabilitation visits limited to a max of 100 per year Habilitation visits limited to a max of 100 per year	$20 Copayment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services (If purchased by your employer, please refer to your Infertility Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	Not covered
Infusion Therapy[4] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment.)	$150 Copayment per medication

Benefits Available on an Outpatient Basis (Continued)

Injectable Drugs [4,8] (Copayment/ Coinsurance not applicable to injectable immunizations, birth control, Infertility and insulin. If injectable drugs are administered in a physician's office, office visit Copayment/ Coinsurance may also apply.)	
Outpatient Injectable Medication	$150 Copayment per medication
Self-Injectable Medication	$150 Copayment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply.)	$15 Copayment
Maternity Care, Tests and Procedures[7]	
PCP Office Visit	No charge
Specialist	No charge
Mental Health Services (including Severe Mental Illness and Serious Emotional Disturbances of Child)	
Outpatient Office Visits include: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling, referral services, and medication management	$40 Office Visit Copayment
All Other Outpatient Treatment include: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, electro-convulsive therapy, psychological testing, facility charges for day treatment centers, Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	No charge
Outpatient Habilitative Services – Outpatient Therapy	$20 Office Visit Copayment
Outpatient Prescription Drug Benefit[8] (Copayment applies per Prescription Unit or up to 30 days)	
Tier 1	$15 Copayment
Tier 2	$35 Copayment
Tier 3	$50 Copayment
Tier 4	25% Copayment up to $250 per script
Prescription Drug Deductible (Per member per Calendar Year) Coinsurance/ Copayment Maximum of $200 for up to a 30 day supply of an orally administered anticancer medication regardless of a Prescription Drug Deductible and/or Medical Deductible.	None
Outpatient Rehabilitation Services – Outpatient Therapy	$20 Office Visit Copayment
Oral Surgery Services[4]	30% Copayment

Benefits Available on an Outpatient Basis (Continued)

Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	30% Copayment
Outpatient Surgery Physician Care	No charge
Pediatric Dental Services **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits
Pediatric Vision Services **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	See your Supplement to the UnitedHealthcare of California for pediatric vision benefits
Physician Care	
PCP Office Visit/ Nonphysician Health Care Practitioner Office Visit	$20 Office Visit Copayment
Specialist	$40 Office Visit Copayment
Preventive Care Services[6,7] (Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an "A" or "B" recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.) Covered Services will include, but are not limited to, the following: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent Care • Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form.	No charge
Prosthetics and Corrective Appliances[4]	$50 Copayment per item
Radiation Therapy[4]	
Standard: (Photon beam radiation therapy)	No charge
Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	$200 Copayment
Radiology Services[4]	
Standard: (Additional Copayment for office visits may apply)	$15 Copayment
Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.	$100 Copayment

Benefits Available on an Outpatient Basis (Continued)

Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	
Specialized Footwear for Foot Disfigurement[4]	$50 Copayment per item
Substance Related and Addictive Disorder	
Outpatient Office Visits include, but are not limited to:	$40 Office Visit Copayment
Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling and detoxifications, referral services, and medication management	No charge
All Other Outpatient Treatment includes, but are not limited to:	
Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, facility charges for day treatment centers, laboratory charges. and methadone maintenance treatment. **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling Customer Service at the telephone number on your ID card.	$20 Copayment
Vision Refractions (For pediatric vision, please refer to your Vision Services Supplement to the Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	$20 Office Visit Copayment

Note: Benefits with Percentage Copayment amounts are based upon the UnitedHealthcare negotiated rate.

[1]Annual Copayment Maximum includes Copayments for UnitedHealthcare benefits including pediatric vision, pediatric dental, behavioral health, prescription drug, chiropractic, and acupuncture benefits. It does not include standalone, separate and independent Dental and Vision benefit plans or infertility benefit, if purchased by the employer group. When an individual member of a family unit satisfies the individual out of pocket maximum for the calendar year, no further out of pocket maximum will be required for that individual member for the remainder of the calendar year. The remaining family members will continue to pay charges until a member or the family as a whole meets the family out of pocket maximum.

[2]Clinical Trial services require preauthorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[3]The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.

[4]Copayment shall never exceed the plan's actual cost of the service. For example, if laboratory costs less than $45 copayment, the lesser amount is the applicable cost sharing amount. (This footnote only applies to dollar copayments.)

[5] Bone anchored hearing aid will be subject to applicable medical/surgical categories (.e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.

[6]Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as No charge. There may be a separate copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your Health Plan ID card.

[7]FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Copayment applies to contraceptive methods and procedures that are **NOT** defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.

[8]Refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Coverage details.

EACH OF THE ABOVE-NOTED BENEFITS IS COVERED WHEN AUTHORIZED BY YOUR PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR URGENTLY NEEDED SERVICE. A UTILIZATION REVIEW COMMITTEE MAY REVIEW THE REQUEST FOR SERVICES.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

The Medical and Hospital Group Subscriber Agreement and the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract will be furnished upon request and is available at the UnitedHealthcare office and your employer's personnel office. UnitedHealthcare's most recent audited financial information is also available upon request.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

PCA727310-001
Platinum / NICE Plan Code: J0M
PRIME Plan Code: AK-QY
Effective 1/1/2017

UnitedHealthcare®

Benefit Summary

Gold Select Plus 750
California - Select Plus
Select Plus Direct - Plan AKR8

What is a benefit summary?

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

What are the benefits of the UnitedHealthcare Select Plus Direct Plan?

Get more protection with a national network and save with Tier 1 providers.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network. You may save even more when you use Tier 1 providers.

> **Pay less by using certain freestanding centers.** Freestanding centers are health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.

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

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

> **Preventive care is covered 100% in our network.**

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

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

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

Benefits At-A-Glance

What you may pay for network care

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

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$20	$750	20%

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

UnitedHealthcare Insurance Company

Your Costs

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

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible		

What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.

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

Medical Deductible - Individual	$750 per year	$1,500 per year
Medical Deductible - Family	$1,500 per year	$3,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.	Included in your medical deductible.

Out-of-Pocket Limit

What is an out-of-pocket limit?

The most you pay during a calendar year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$5,500 per year	$11,000 per year
Out-of-Pocket Limit - Family	$11,000 per year	$22,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.

Your Costs

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

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acupuncture Services		
	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
Non-Emergency	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Breast Cancer Services		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	20% co-insurance after you pay the $250 co-pay per Inpatient Stay and the medical deductible has been met.	Out-of-Network Benefits are not available.
Dental Anesthesia Services		
Limited to Covered Persons who are one of the following: A child under seven years of age. A person who is developmentally disabled, regardless of age. A person whose health is compromised and for whom general anesthesia is required, regardless of age.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Fluoride Treatments	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Sealants (Protective Coating) Limited to once per first or second permanent molar.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Space Maintainers	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Dental - Pediatric Diagnostic Services		
Periodic Oral Evaluation (Check-up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Radiographs Limited to 2 series of films per 12 months for Bitewing and 1 time per 24 months for Complete/Panorex.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
General Services (Including Emergency treatment) Palliative Treatment: Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General Anesthesia: Covered when clinically necessary. Occlusal Guard: Limited to 1 guard every 12 months.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Oral Surgery (Including Surgical Extractions)	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to 5 quadrants in any 12 months. Scaling and Root Planing: Limited to 5 quadrants per 12 months. Periodontal Maintenance: Limited to 5 quadrant treatments per 12 months. In conjunction with dental prophylaxis, following active and adjunctive periodontal therapy, exclusive of gross debridement.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Restorations (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as one filling.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal)	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Dental - Pediatric Major Restorative Services		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 36 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Dentures and other removable Prosthetics (Full denture/partial denture) Limited to 1 time per 36 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Fixed Partial Dentures (Bridges) Limited to 5 units of bridgework per arch.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization required for orthodontic treatment.	Prior Authorization required for orthodontic treatment.
Dental Services - Accident Only		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Diabetes Treatment		
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.	The amount you pay is based on where the covered health service is provided. Benefits for diabetes supplies will be the same as those stated in section 12 of the COC.	
Durable Medical Equipment		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services - Outpatient		
	$100 co-pay per visit. A deductible does not apply.	$100 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Enteral Formula and Amino Acid-Modified Food Products (Medical Foods)		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Habilitative Services are limited to: 24 visits of manipulative treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Hearing Aids		
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years. This limit does not apply to bone-anchored hearing aids.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 100 visits per year.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	20% co-insurance after you pay the $250 co-pay per Inpatient Stay and the medical deductible has been met.	50% co-insurance after you pay the $250 co-pay per Inpatient Stay and the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Infertility Services		
Limited to $2,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	20% co-insurance, after the medical deductible has been met for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office. 20% co-insurance after you pay the $250 co-pay per service and the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center.	50% co-insurance, after the medical deductible has been met for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office. 50% co-insurance after you pay the $250 co-pay per service and the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center. Prior Authorization is required for certain services.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	20% co-insurance, after the medical deductible has been met for services provided at a freestanding diagnostic center or in a physician's office. 20% co-insurance after you pay the $250 co-pay per service and the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.	50% co-insurance, after the medical deductible has been met for services provided at a freestanding diagnostic center or in a physician's office. 50% co-insurance after you pay the $250 co-pay per service and the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center. Prior Authorization is required.
Mastectomy Services		
	The amount you pay is based on where the covered health service is provided.	

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient Office Visits:	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
All Other Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Nicotine Use Benefit		
Benefits for nicotine use medications are provided under the Outpatient Prescription Drug Schedule of Benefits. Tobacco use and tobacco-related disease counseling and interventions and medications required to be provided under the Preventive Care Services benefit by the Patient Protection and Affordable Care Act are not subject to any cost sharing when provided by Network providers.	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Obesity Surgery		
Obesity surgery is covered when received at a designated facility. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.	Out-of-Network Benefits are not available.
Off-Label Drug Use and Experimental or Investigational Services		
	The amount you pay is based on where the covered health service is provided.	
Orthotic Benefit		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Osteoporosis Services		
	The amount you pay is based on where the covered health service is provided.	
Ostomy and Urological Supplies		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) Treatment		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Physician Fees for Surgical and Medical Services		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Physician's Office Services		
Primary Physician Office Visit	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$40 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.		
Pregnancy - Maternity Services		
We pay for Covered Health Services incurred if you participate in the Expanded Alpha Feto Protein (AFP) program, a statewide prenatal testing program administered by the State Department of Health Services.	The amount you pay is based on where the covered health service is provided. Prenatal care office visits received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy. The first postnatal/postpartum visit is covered at no charge. The amount you pay for subsequent postnatal/ postpartum care is based on where the covered health service is provided.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	Out-of-Network Benefits are not available.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Rehabilitation Services are limited to: 24 visits of manipulative treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office. 20% co-insurance after you pay the $250 co-pay per date of service and the medical deductible has been met for services provided at an outpatient hospital-based center.	50% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office. 50% co-insurance after you pay the $250 co-pay per date of service and the medical deductible has been met for services provided at an outpatient hospital-based center.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services (Including Habilitative Services During an Inpatient Stay)		
Limited to 100 days per benefit period for Skilled Nursing Facility. Inpatient rehabilitation facility services are unlimited. Inpatient habilitative services are unlimited.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Specialized Footwear		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Substance Use Disorder Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient Office Visits:	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
All Other Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Surgery - Outpatient		
	20% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. 20% co-insurance after you pay the $250 co-pay per date of service and the medical deductible has been met for services provided at an outpatient hospital-based surgical center.	50% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. 50% co-insurance after you pay the $250 co-pay per date of service and the medical deductible has been met for services provided at an outpatient hospital-based surgical center. Prior Authorization is required for certain services.
Telehealth Services		
	The amount you pay is based on where the covered health service is provided.	

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Temporomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Out-of-Network Benefits are not available.
Urgent Care Center Services		
	$50 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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.	$20 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Routine Vision Examination Limited to once every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	20% co-insurance. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.	You pay nothing. A deductible does not apply.
Eyeglass Frames Limited to once every 12 months.	20% co-insurance. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Contact Lenses/Necessary Contact Lenses You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	20% co-insurance. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Low Vision Services		
Low Vision Comprehensive Evaluation Limited to once every 24 months.	You pay nothing for Low Vision Comprehensive Evaluation. A deductible does not apply.	25% co-insurance for Low Vision Comprehensive Evaluation. A deductible does not apply.
Low Vision Follow-up Care Limited to four visits in any 5 year period.	You pay nothing for Low Vision Follow-up Care. A deductible does not apply.	25% co-insurance for Low Vision Follow-up Care. A deductible does not apply.
Low vision aid such as high-power spectacles, magnifiers and telescopes. Limited to once every 12 months.	25% co-insurance for Low Vision aid such as high-power spectacles, magnifiers and telescopes. A deductible does not apply.	25% co-insurance for Low Vision aid such as high-power spectacles, magnifiers and telescopes. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision Examination (Benefit is for Covered Persons over age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 12 months.	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

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

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to general anesthesia and associated Hospital or Alternate Facility charges for which Benefits are provided as described under Dental Anesthesia Services in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of an acute traumatic health condition, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth. This exclusion does not apply to dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Denials of coverage are subject to Independent Medical Review for Experimental and Investigational Therapies. Dispensing of drugs/medications not normally supplied in a dental office. Replacement of loss or theft of dentures or bridgework. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Certificate. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Dental implants are excluded, but it is considered optional dental treatment. An optional benefit is a dental benefit that you choose to have upgraded. For example when a filling would correct the tooth but you choose to have a full crown instead. If you choose to have an implant rather than a Covered Dental Service such as a denture or fixed bridge, we will pay our cost share of the Covered Dental Service and you will be responsible for the additional cost of the upgrade to a dental implant. Orthodontic treatment unless medically necessary as described under Medically Necessary Orthodontic Services in Section 10 of the COC. Surgical removal of impacted teeth is Covered Dental Service only when evidence of pathology exists.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC and speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and is required by California law when prescribed by a Network provider for which Beneifts are available without cost sharing, as described under Preventive Care in Section 1 of the COC. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC. Growth hormone therapy, except when Medically Necessary. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under Section 9: Defined Terms and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the American Hospital Formulary Service's Drug Information; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Shoes. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Shoe orthotics. This exclusion does not apply to shoes for which Benefits are provided as described under Specialized Footwear in Section 1 of the COC. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Arch supports. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings. This exclusion does not apply to:

- Lymphedema gradient compression stockings for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC.
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.
- Ostomy and urological supplies for which Benefits are provided as described under Ostomy and Urological Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified as mental disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Only Mental Health Services as treatments for R and T code conditions as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association chapters entitled "Medication-Induced Movement Disorders and Other Adverse Effects of Medication" and "Other Conditions That May Be a Focus of Clinical Attention" are excluded. Educational services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness or Serious Emotional Disturbances in Section 9 of the COC. Tuition or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies or Pharmaceutical Products, that are all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Enteral feedings, even if the sole source of nutrition, except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods), except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers. This exclusion does not apply to batteries for home blood glucose monitors and infusion pumps as described under Diabetes Treatment and Durable Medical Equipment in Section 1 of the COC; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement and as required by California regulation); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. This exclusion does not apply to the surgical or non-surgical treatment of morbid obesity for which Benefits are provided as described under Obesity Surgery in Section 1 of the COC. This exclusion does not apply to services that have in effect the current recommendations of the United States Preventive Services Task Force for obesity screening in children, adolescents and all adults as described under Preventive Care Services in Section 1: of the COC. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations; and physical therapy modalities that have general value but show limited or no efficacy in the treatment of TMJ including cold laser, diathermy, thermography, iontophoresis, biofeedback, and TENS. Upper and lower jawbone surgery except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in Temporomandibular Joint (TMJ) Services under Section 1 of the COC. Orthognathic surgery, and jaw alignment, except as a treatment of obstructive sleep apnea. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under Other Health Education Services for You in the section of the Certificate titled Our Responsibilities. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under Preventive Care Services in Section 1 of the COC. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility. Obesity surgery that is not received at a Designated Facility.

Providers

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

Services your plan does not cover (Exclusions)

Reproduction

The following infertility treatment-related services: Cryo-preservation and other forms of preservation of reproductive materials. Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue. Donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. The reversal of voluntary sterilization.

Services Provided under Another Plan

Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Severe Mental Illness and Serious Emotional Disturbances in Section 9 of the COC. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, that are all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. This exclusion does not apply to Medically Necessary pain management for acute and chronic pain provided during an Inpatient Stay in a Hospital. Custodial care or maintenance care. This exclusion does not apply to Custodial Care or maintenance care for which Benefits are provided under Home Health Care, Hospice Care, Hospital - Inpatient Stay, and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services in Section 1 of the COC. Domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. This exclusion does not apply to services for which Benefits are provided under Hospice Care and Home Health Care in Section 1 of the COC. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Services your plan does not cover (Exclusions)

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. This exclusion does not apply to special contact lenses for aniridia and aphakia for which Benefits are provided as described under Vision Examinations in Section 1 of the COC. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). This exclusion does not apply to contact lenses for aniridia (missing iris) and aphakia (absence of crystalline lens of the eye). Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when the Covered Person has either of the following Craniofacial anomalies in which normal or absent ear canals preclude the use of a wearable hearing aid; or Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services for the following: Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following: Medically Necessary. Not otherwise excluded in Section 2 of the COC. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in the United States or in non-war zones outside of the United States. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an Out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

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UnitedHealthcare Insurance Company

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UnitedHealthcare®

Benefit Summary

Bronze Select Plus HSA 6500
California - Select Plus
HSA - Plan AKRX

What is a benefit summary?

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

What are the benefits of the Select Plus Plan with an HSA?

Get network freedom and an HSA.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network. You can save money when you use the health savings account (HSA) and the network.

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

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

> **Preventive care is covered 100% in our network.**

> **You can open a health savings account (HSA).** An HSA is a personal bank account to help you save and pay for your health care, and help you save on taxes.

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

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

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

Benefits At-A-Glance

What you may pay for network care

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

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
You have no co-payment.	$6,500	You have no co-insurance.

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

UnitedHealthcare Insurance Company

Your Costs

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

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible - Combined Medical and Pharmacy		
What is a deductible?		
The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$6,500 per year	$9,000 per year
Medical Deductible - Family	$13,000 per year	$18,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.	Included in your medical deductible.
Out-of-Pocket Limit - Combined Medical and Pharmacy		
What is an out-of-pocket limit?		
The most you pay during a calendar year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
Out-of-Pocket Limit - Individual	$6,500 per year	$13,000 per year
Out-of-Pocket Limit - Family	$13,000 per year	$26,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.

Your Costs

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

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acupuncture Services		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
Non-Emergency	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Breast Cancer Services		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	You pay nothing, after the medical deductible has been met.	Out-of-Network Benefits are not available.
Dental Anesthesia Services		
Limited to Covered Persons who are one of the following: A child under seven years of age. A person who is developmentally disabled, regardless of age. A person whose health is compromised and for whom general anesthesia is required, regardless of age.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Fluoride Treatments	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Sealants (Protective Coating) Limited to once per first or second permanent molar.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Space Maintainers	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Dental - Pediatric Diagnostic Services		
Periodic Oral Evaluation (Check-up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Radiographs Limited to 2 series of films per 12 months for Bitewing and 1 time per 24 months for Complete/Panorex.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	You pay nothing, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
General Services (Including Emergency treatment) Palliative Treatment: Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General Anesthesia: Covered when clinically necessary. Occlusal Guard: Limited to 1 guard every 12 months.	You pay nothing, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Oral Surgery (Including Surgical Extractions)	You pay nothing, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to 5 quadrants in any 12 months. Scaling and Root Planing: Limited to 5 quadrants per 12 months. Periodontal Maintenance: Limited to 5 quadrant treatments per 12 months. In conjunction with dental prophylaxis, following active and adjunctive periodontal therapy, exclusive of gross debridement.	You pay nothing, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Restorations (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as one filling.	You pay nothing, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal)	You pay nothing, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Dental - Pediatric Major Restorative Services		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 36 months.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Dentures and other removable Prosthetics (Full denture/partial denture) Limited to 1 time per 36 months.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Fixed Partial Dentures (Bridges) Limited to 5 units of bridgework per arch.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization required for orthodontic treatment.	Prior Authorization required for orthodontic treatment.
Dental Services - Accident Only		
	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Diabetes Treatment		
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.	The amount you pay is based on where the covered health service is provided. Benefits for diabetes supplies will be the same as those stated in section 12 of the COC.	
Durable Medical Equipment		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services - Outpatient		
	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Enteral Formula and Amino Acid-Modified Food Products (Medical Foods)		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Habilitative Services are limited to: 24 visits of manipulative treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Hearing Aids		
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years. This limit does not apply to bone-anchored hearing aids.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 100 visits per year.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Infertility Services		
Limited to $2,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Mastectomy Services		
	The amount you pay is based on where the covered health service is provided.	
Mental Health Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient Office Visits:	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
All Other Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Nicotine Use Benefit		
Benefits for nicotine use medications are provided under the Outpatient Prescription Drug Schedule of Benefits. Tobacco use and tobacco-related disease counseling and interventions and medications required to be provided under the Preventive Care Services benefit by the Patient Protection and Affordable Care Act are not subject to any cost sharing when provided by Network providers.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Obesity Surgery		
Obesity surgery is covered when received at a designated facility. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.	You pay nothing, after the medical deductible has been met. Prior Authorization is required.	Out-of-Network Benefits are not available.
Off-Label Drug Use and Experimental or Investigational Services		
	The amount you pay is based on where the covered health service is provided.	
Orthotic Benefit		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Osteoporosis Services		
	The amount you pay is based on where the covered health service is provided.	
Ostomy and Urological Supplies		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) Treatment		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Physician Fees for Surgical and Medical Services		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician's Office Services		
Primary Physician Office Visit	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Pregnancy - Maternity Services		
We pay for Covered Health Services incurred if you participate in the Expanded Alpha Feto Protein (AFP) program, a statewide prenatal testing program administered by the State Department of Health Services.	The amount you pay is based on where the covered health service is provided. Prenatal care office visits received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy. The first postnatal/postpartum visit is covered at no charge. The amount you pay for subsequent postnatal/ postpartum care is based on where the covered health service is provided.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	Out-of-Network Benefits are not available.

Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prosthetic Devices		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Rehabilitation Services are limited to: 24 visits of manipulative treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services (Including Habilitative Services During an Inpatient Stay)		
Limited to 100 days per benefit period for Skilled Nursing Facility. Inpatient rehabilitation facility services are unlimited. Inpatient habilitative services are unlimited.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Specialized Footwear		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Substance Use Disorder Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient Office Visits:	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
All Other Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Surgery - Outpatient		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telehealth Services		
	The amount you pay is based on where the covered health service is provided.	
Temporomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Out-of-Network Benefits are not available.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Urgent Care Center Services		
	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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.	You pay nothing, after the medical deductible has been met.	Out-of-Network Benefits are not available.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Routine Vision Examination Limited to once every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass Lenses Limited to once every 12 months.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Eyeglass Frames Limited to once every 12 months.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Contact Lenses/Necessary Contact Lenses You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	You pay nothing, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Low Vision Services		
Low Vision Comprehensive Evaluation Limited to once every 24 months.	You pay nothing for Low Vision Comprehensive Evaluation. A deductible does not apply.	25% co-insurance for Low Vision Comprehensive Evaluation, after the medical deductible has been met.
Low Vision Follow-up Care Limited to four visits in any 5 year period.	You pay nothing for Low Vision Follow-up Care. A deductible does not apply.	25% co-insurance for Low Vision Follow-up Care, after the medical deductible has been met.
Low vision aid such as high-power spectacles, magnifiers and telescopes. Limited to once every 12 months.	You pay nothing for Low Vision aid such as high-power spectacles, magnifiers and telescopes. The medical deductible does not apply.	25% co-insurance for Low Vision aid such as high-power spectacles, magnifiers and telescopes, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision Examination (Benefit is for Covered Persons over age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

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

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to general anesthesia and associated Hospital or Alternate Facility charges for which Benefits are provided as described under Dental Anesthesia Services in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of an acute traumatic health condition, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth. This exclusion does not apply to dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Denials of coverage are subject to Independent Medical Review for Experimental and Investigational Therapies. Dispensing of drugs/medications not normally supplied in a dental office. Replacement of loss or theft of dentures or bridgework. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Certificate. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Dental implants are excluded, but it is considered optional dental treatment. An optional benefit is a dental benefit that you choose to have upgraded. For example when a filling would correct the tooth but you choose to have a full crown instead. If you choose to have an implant rather than a Covered Dental Service such as a denture or fixed bridge, we will pay our cost share of the Covered Dental Service and you will be responsible for the additional cost of the upgrade to a dental implant. Orthodontic treatment unless medically necessary as described under Medically Necessary Orthodontic Services in Section 10 of the COC. Surgical removal of impacted teeth is Covered Dental Service only when evidence of pathology exists.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC and speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and is required by California law when prescribed by a Network provider for which Beneifts are available without cost sharing, as described under Preventive Care in Section 1 of the COC. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC. Growth hormone therapy, except when Medically Necessary. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under Section 9: Defined Terms and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the American Hospital Formulary Service's Drug Information; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Shoes. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Shoe orthotics. This exclusion does not apply to shoes for which Benefits are provided as described under Specialized Footwear in Section 1 of the COC. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Arch supports. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings. This exclusion does not apply to:

- Lymphedema gradient compression stockings for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC.
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.
- Ostomy and urological supplies for which Benefits are provided as described under Ostomy and Urological Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified as mental disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Only Mental Health Services as treatments for R and T code conditions as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association chapters entitled "Medication-Induced Movement Disorders and Other Adverse Effects of Medication" and "Other Conditions That May Be a Focus of Clinical Attention" are excluded. Educational services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness or Serious Emotional Disturbances in Section 9 of the COC. Tuition or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies or Pharmaceutical Products, that are all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Enteral feedings, even if the sole source of nutrition, except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods), except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers. This exclusion does not apply to batteries for home blood glucose monitors and infusion pumps as described under Diabetes Treatment and Durable Medical Equipment in Section 1 of the COC; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement and as required by California regulation); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. This exclusion does not apply to the surgical or non-surgical treatment of morbid obesity for which Benefits are provided as described under Obesity Surgery in Section 1 of the COC. This exclusion does not apply to services that have in effect the current recommendations of the United States Preventive Services Task Force for obesity screening in children, adolescents and all adults as described under Preventive Care Services in Section 1: of the COC. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations; and physical therapy modalities that have general value but show limited or no efficacy in the treatment of TMJ including cold laser, diathermy, thermography, iontophoresis, biofeedback, and TENS. Upper and lower jawbone surgery except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in Temporomandibular Joint (TMJ) Services under Section 1 of the COC. Orthognathic surgery, and jaw alignment, except as a treatment of obstructive sleep apnea. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under Other Health Education Services for You in the section of the Certificate titled Our Responsibilities. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under Preventive Care Services in Section 1 of the COC. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility. Obesity surgery that is not received at a Designated Facility.

Providers

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

Services your plan does not cover (Exclusions)

Reproduction

The following infertility treatment-related services: Cryo-preservation and other forms of preservation of reproductive materials. Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue. Donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. The reversal of voluntary sterilization.

Services Provided under Another Plan

Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Severe Mental Illness and Serious Emotional Disturbances in Section 9 of the COC. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, that are all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. This exclusion does not apply to Medically Necessary pain management for acute and chronic pain provided during an Inpatient Stay in a Hospital. Custodial care or maintenance care. This exclusion does not apply to Custodial Care or maintenance care for which Benefits are provided under Home Health Care, Hospice Care, Hospital - Inpatient Stay, and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services in Section 1 of the COC. Domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. This exclusion does not apply to services for which Benefits are provided under Hospice Care and Home Health Care in Section 1 of the COC. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Services your plan does not cover (Exclusions)

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. This exclusion does not apply to special contact lenses for aniridia and aphakia for which Benefits are provided as described under Vision Examinations in Section 1 of the COC. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). This exclusion does not apply to contact lenses for aniridia (missing iris) and aphakia (absence of crystalline lens of the eye). Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when the Covered Person has either of the following Craniofacial anomalies in which normal or absent ear canals preclude the use of a wearable hearing aid; or Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services for the following: Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following: Medically Necessary. Not otherwise excluded in Section 2 of the COC. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in the United States or in non-war zones outside of the United States. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an Out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

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UnitedHealthcare®

dental plan

Consumer MaxMultiplier Voluntary Options PPO 20/covered dental services

P3306 /MAC

	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.)*	$1000 per person per calendar year	$1000 per person per calendar year
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Waiting Period	12 months for major services	

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	80%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	80%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	80%	
PREVENTIVE SERVICES			
Dental Prophylaxis (Cleanings)	100%	80%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	80%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	80%	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%	80%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations *(Amalgam or Anterior Composite)***	80%	50%	Multiple restorations on one surface will be treated as a single filling.
General Services *(including Emergency Treatment)*	80%	50%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary. Occlusal Guard: Limited to 1 guard every consecutive 36 months.
Simple Extractions	80%	50%	Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Oral Surgery *(includes surgical extractions)*	50%	50%	
Periodontics	50%	50%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Endodontics	50%	50%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
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 allowable amount applicable for the same service that would have been rendered by a network provider.

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. Proviced 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

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

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.

SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

RESTORATIONS Multiple restorations on one surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

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.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

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.

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.

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.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only when clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

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

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any dental procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. 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.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. 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.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been covered under the policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the Policy for 12 continuous months.
15. 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.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. 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.
22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
23. 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.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
27. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
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.

Plan V1043

UnitedHealthcare®

Vision Benefit Summary

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

myuhcvision.com

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.
In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 15.00
Materials	$ 30.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating,Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider). The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit[2] (Selection contact lenses refers to our formulary contact list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at myuhcvision.com).	
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-selection contact lenses An allowance is applied toward the purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.	$105.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
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 Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[2]	Up to $105.00
Necessary Contacts in Lieu of Eyeglasses[3]	Up to $210.00

Discounts	
	Laser vision UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik*Plus*® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.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.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.

[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 in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. 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.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your $105.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. 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.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
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 full fee 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. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. 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.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

FiSec Global Inc.,				
	Employee	Empl + Spouse	Empl + Child	Empl + Family
Dental P3306	$ 38.85	$ 77.70	$ 78.43	$ 120.89
Vision V1043	$ 7.53	$ 14.30	$ 16.71	$ 23.55

Medical Age	PPO - Bronze Select Plus AK-RX / RX396	PPO - Gold Select Plus AK-R8 / RX583	HMO - Platinum Signature AK-QY / RX406	Employer Contribution to Employee
<21	$ 201.17	$ 270.24	$ 332.17	$ 100.59
21	$ 316.80	$ 425.57	$ 523.11	$ 158.40
22	$ 316.80	$ 425.57	$ 523.11	$ 158.40
23	$ 316.80	$ 425.57	$ 523.11	$ 158.40
24	$ 316.80	$ 425.57	$ 523.11	$ 158.40
25	$ 318.07	$ 427.27	$ 525.20	$ 159.04
26	$ 324.40	$ 435.78	$ 535.66	$ 162.20
27	$ 332.01	$ 446.00	$ 548.22	$ 166.01
28	$ 344.36	$ 462.59	$ 568.62	$ 172.18
29	$ 354.50	$ 476.21	$ 585.36	$ 177.25
30	$ 359.57	$ 483.02	$ 593.73	$ 179.79
31	$ 367.17	$ 493.24	$ 606.28	$ 183.59
32	$ 374.77	$ 503.45	$ 618.84	$ 187.39
33	$ 379.53	$ 509.83	$ 626.69	$ 189.77
34	$ 384.60	$ 516.64	$ 635.06	$ 192.30
35	$ 387.13	$ 520.05	$ 639.24	$ 193.57
36	$ 389.66	$ 523.45	$ 643.43	$ 194.83
37	$ 392.20	$ 526.86	$ 647.61	$ 196.10
38	$ 394.73	$ 530.26	$ 651.80	$ 197.37
39	$ 399.80	$ 537.07	$ 660.16	$ 199.90
40	$ 404.87	$ 543.88	$ 668.53	$ 202.44
41	$ 412.47	$ 554.09	$ 681.09	$ 206.24
42	$ 419.76	$ 563.88	$ 693.12	$ 209.88
43	$ 429.90	$ 577.50	$ 709.86	$ 214.95
44	$ 442.57	$ 594.52	$ 730.78	$ 221.29
45	$ 457.46	$ 614.52	$ 755.37	$ 228.73
46	$ 475.20	$ 638.36	$ 784.67	$ 237.60
47	$ 495.16	$ 665.17	$ 817.62	$ 247.58
48	$ 517.97	$ 695.81	$ 855.28	$ 258.99
49	$ 540.46	$ 726.02	$ 892.43	$ 270.23
50	$ 565.80	$ 760.07	$ 934.27	$ 282.90
51	$ 590.83	$ 793.69	$ 975.60	$ 295.42
52	$ 618.39	$ 830.71	$ 1,021.11	$ 309.20
53	$ 646.27	$ 868.16	$ 1,067.14	$ 323.14
54	$ 676.37	$ 908.59	$ 1,116.84	$ 338.19
55	$ 706.46	$ 949.02	$ 1,166.54	$ 353.23
56	$ 739.09	$ 992.85	$ 1,220.42	$ 369.55
57	$ 772.04	$ 1,037.11	$ 1,274.82	$ 386.02
58	$ 807.21	$ 1,084.35	$ 1,332.88	$ 403.61
59	$ 824.63	$ 1,107.76	$ 1,361.66	$ 412.32
60	$ 859.80	$ 1,155.00	$ 1,419.72	$ 429.90
61	$ 890.21	$ 1,195.85	$ 1,469.94	$ 445.11
62	$ 910.17	$ 1,222.66	$ 1,502.90	$ 455.09
63	$ 935.19	$ 1,256.28	$ 1,544.22	$ 467.60
64+	$ 950.40	$ 1,276.71	$ 1,569.33	$ 475.20