UnitedHealthcare®

Benefit Summary

Select Plus PPO Platinum
California - Select Plus
Traditional - Plan BHBN

What is a benefit summary?

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

What are the benefits of the Select Plus Plan?

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

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

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

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

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

Are you a member?

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

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

Not enrolled yet? 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.

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)
$10	You have no individual deductible.	10%

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

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
Annual Deductible		
What is an annual deductible?		
The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	You do not have to pay a medical deductible.	$1,000 per year
Medical Deductible - Family	You do not have to pay a medical deductible.	$2,000 per year
Dental - Pediatric Services Deductible - Individual	You do not have to pay a dental deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	You do not have to pay a dental deductible.	Included in your medical deductible.
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.		
> 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	$3,200 per year	$6,400 per year
Out-of-Pocket Limit - Family	$6,400 per year	$12,800 per year

Your Costs

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

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.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acupuncture Services		
	$10 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency Ambulance:	10% co-insurance. A deductible does not apply.	10% co-insurance. A deductible does not apply.
Non-Emergency Ambulance:	10% co-insurance. A deductible does not apply.	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 care service is provided.	
Cellular and Gene Therapy		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	Out-of-Network Benefits are not available.
	Prior Authorization is required.	
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	Benefits will be the same as stated under Hospital - Inpatient Stay.	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; or a person whose health is compromised and for whom general anesthesia is required, regardless of age.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.

Your Costs

Covered Health Care Services	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 1 time every 6 months.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Fluoride Treatments Limited to 1 time every 6 months.	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 every 36 months.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Space Maintainers (Spacers) Limited to once per provider, per quadrant or arch per lifetime.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Dental - Pediatric Diagnostic Services		
Evaluations (Check-up Exams) Limited to 1 time per 6 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.
Intraoral Radiographs (X-ray) Limited to 1 series of films per 6 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.

Your Costs

Covered Health Care Services	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. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Adjunctive Services Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General Anesthesia: Covered only when clinically Necessary. Occlusal Guard: Limited to one guard every 12 months per quadrant per provider.	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Oral Surgery	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to one every 36 months per surgical area. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis.	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as a single filling and limited to 1 per tooth per 12 months.	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Major Restorative Services		
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
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. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for orthodontic treatment.	Prior Authorization is required for orthodontic treatment.
Dental Services - Accident Only		
	10% co-insurance. A deductible does not apply.	10% co-insurance. A deductible does not apply.
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	You pay nothing. A deductible does not apply	50% co-insurance, after the medical deductible has been met.
Diabetes Self-Management Items:	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for DME that costs more than $1,000.
Diabetes Treatment		
	The amount you pay is based on where the covered health care service is provided. Benefits for certain diabetes supplies will be the same as those stated in section 12 of the COC.	

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Durable Medical Equipment (DME), Orthotics and Supplies		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for DME or orthotics that costs more than $1,000.
Emergency Health Care Services - Outpatient		
	After you pay the $150 co-pay per visit; you pay 10% co-insurance. A deductible does not apply.	After you pay the $150 co-pay per visit; you pay 10% co-insurance. A deductible does not apply.
Enteral Formula and Amino Acid-Modified Food Products (Medical Foods)		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided.	
Habilitative Services		
Inpatient:	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies are limited per year as follows: 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.	$10 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 Inpatient services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Hearing Aids		
Limited to $2,500 every year. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. This limit does not apply to bone-anchored hearing aids.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Home Health Care		
Services other than Rehabilitative and Habilitative limited to 100 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Habilitative care limited to 100 visits per calendar year (counting all home health care visits). Rehabilitative care limited to 100 visits per calendar year (counting all home health care visits). To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	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. This limit includes Benefits for infertility medications provided under the Outpatient Prescription Drug Schedule of Benefits. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under Physician's Office Services.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient:	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for sleep studies, stress echocardiography and transthoracic echocardiogram services.
Major Diagnostic and Imaging - Outpatient		
	10% co-insurance. A deductible does not apply.	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 care service is provided.	
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Outpatient Office Visits:	$10 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
All Other Outpatient Treatment:	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
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.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Obesity - Weight Loss Surgery		
Obesity surgery is covered when received at a designated facility and performed by a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.	The amount you pay is based on where the covered health care service is provided. 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 care service is provided.	
Orthotic Benefit		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for orthotic devices that cost more than $1,000.
Osteoporosis Services		
	The amount you pay is based on where the covered health care service is provided.	
Ostomy and Urological Supplies		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
Applies to drugs administered by a provider on an outpatient basis. This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Phenylketonuria (PKU) Treatment		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Physician Fees for Surgical and Medical Services		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Physician's Office Services		
	$10 co-pay per visit for a primary care physician office visit. A deductible does not apply. $20 co-pay per visit for a specialist office visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing.
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 Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.	The amount you pay is based on where the covered health care 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 care service is provided.	The amount you pay is based on where the covered health care 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.		

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Preventive Care Services		
Physician Office Services, 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		
	10% co-insurance. A deductible does not apply.	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 care service is provided.	Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
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.	$10 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance. A deductible does not apply.	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.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Specialized Footwear		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for specialized footwear that costs more than $1,000.
Surgery - Outpatient		
	10% co-insurance. A deductible does not apply.	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 care service is provided.	
Temporomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. 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.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$5 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available.

Covered Health Care Services	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 Exam 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.	10% 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.	10% co-insurance. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	10% co-insurance. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Low Vision Care 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.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision Exams (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 calendar year. Limited to 2 contact lenses per eye (including fitting and dispensing) per 12-month period to treat aniridia. Limited to 6 contact lenses per eye (including fitting and dispensing) per 12-month period to treat aphakia.	$10 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

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

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

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

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

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug Products

California Plan 854

Standard Drugs: 10/35/70/25%

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on **myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Out-of-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network	
Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

Out-of-Pocket Limit does not apply to Ancillary Charges.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with Certificate of Coverage, the Certificate of Coverage shall prevail.

UnitedHealthcare Insurance Company

Tier Level	Up to 31-day supply			Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	**Retail Non-Preferred Specialty Network Pharmacy**	**Retail Out-of-Network Pharmacy**	***Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy**
Tier 1 Prescription Drug Products	**$10**	**$20**	**$10**	**$25**
Tier 2 Prescription Drug Products	**$35**	**$70**	**$35**	**$87.50**
Tier 3 Prescription Drug Products	**$70**	**$140**	**$70**	**$175**
Tier 4 Prescription Drug Products	**25% however you will not pay more than $250**	**50% however you will not pay more than $500**	**25% however you will not pay more than $250**	**25% however you will not pay more than $625**

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. When you choose the higher cost drug of the two, you will pay the difference between the higher cost drug and the lower cost drug in addition to your Co-payment and/or Co-insurance that applies to the lower cost drug. The Ancillary Charge may not apply to any Out of Pocket Limit.

Other Important Information about your Outpatient Prescription Drug Benefits

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-network Pharmacy's Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. If the Usual and Customary Charge (retail price) of the Prescription Drug Product is less than the applicable co-payment, you are responsible for paying the retail price. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. You may request a pharmacist to dispense partial fill on a prescription for an oral, solid dosage Schedule II controlled Prescription Drug Product, and we will prorate your cost sharing for the partial fill.Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

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

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Schedule of Benefits or Pharmaceutical Products for which Benefits are described in your Certificate are subject to step therapy requirements. Step therapy is a process whereby Prescription Drug Products or Pharmaceutical Products are filled with an effective, but more affordable medication. When appropriate, a more costly medication can be authorized if the Prescription Drug Product or Pharmaceutical Product is not effective in treating the Covered Person's condition. Step therapy is designed to encourage the use of cost-effective Prescription Drug Products or Pharmaceutical Products when appropriate. If the Covered Person's Physician determines that a Prescription Drug Product is or Pharmaceutical Product subject to the step therapy requirements is not medically appropriate or is not satisfactorily treating the Covered Person's condition, the Physician can request an exception to the step therapy process by contacting us at www.unitedhealthcareonline.com. In the case of a standard exception request, we will notify the Covered Person or the Covered Person's designee or the Covered Person's prescribing provider of the Benefit determination no later than 72 hours following receipt of the request. When we grant a standard exception request, we will provide coverage of the Prescription Drug Product for the duration of the prescription, including refills. In the case of an expedited exception request based on exigent circumstances, we will notify the Covered Person or the Covered Person's designee or the Covered Person's prescribing provider of the Benefit determination no later than 24 hours following receipt of the request. When we grant an exception based on exigent circumstances, we will provide coverage of the Prescription Drug Product (including refills) for the duration of the exigency. Exigent circumstances exist when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or when the Covered Person is undergoing a current course of treatment using a Prescription Drug Product that is not on the Prescription Drug List (PDL). External exception request review. If we deny a request for a standard exception or for an expedited exception, the Covered Person, the Covered Person's designee, or the Covered Person's prescribing provider may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. A denial of a request for an exception is subject to Independent Medical Review (IMR). The IMR process is described under Section 6: Questions, Complaints and Appeals. The Independent Medical Review Organization will make a determination on the external exception request and notify the Covered Person or the Covered Person's designee and the prescribing provider of the Benefit determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request. If the Independent Medical Review Organization grants an external exception review of a standard exception request, we will provide coverage of the Prescription Drug Product that is not on the Prescription Drug List (PDL) for the duration of the prescription. If the Independent Medical Review Organization grants an external exception review of an expedited exception request, we will provide coverage of the Prescription Drug Product that is not on the Prescription Drug List (PDL) for the duration of the exigency. Per CIC § 10123.191(b) of the California Insurance Code, if the insurer fails to respond to the prescribing provider within the prescribed time limits, the request is deemed granted. If the Covered Person is changing policies, we will not require the Covered Person to repeat step therapy when the Covered Person is already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for the Covered Person's medical condition. However, we may impose a prior authorization requirement for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy requirements imposed by the former policy. The prescribing provider may also prescribe another Prescription Drug Product covered under this Policy that is medically appropriate for the Covered Person's medical condition. You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the internet at www.myuhc.com® or by calling the telephone number on your ID card. A request for an exception to the step therapy requirements may be submitted in the same manner as a request for prior authorization for Prescription Drug Products as described in Prior Authorization Requirements of this Outpatient Prescription Drug Schedule of Benefits.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved

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

If you require certain Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at myuhc.com® or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid. If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you may be subject to the Out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you may be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

Certain PPACA Zero Cost Share Preventive Care Medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, or Annual Drug Deductible) as required by applicable law. You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at myuhc.com® or the telephone number on your ID card.

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

PHARMACY EXCLUSIONS

The following limitations apply to these services. In addition see your COC and SBN for additional exclusions and limitations that may apply.

Limitations

- Experimental, Investigational or Unproven Services and medications; medications used for Experimental indications and/or dosage regimens that are Experimental, Investigational or Unproven. If Benefits are denied as an Experimental, Investigational or Unproven Service, the Covered Person may appeal the decision through independent external medical review as described under Denial of Experimental, Investigational or Unproven Services in Section 6 of the COC. You may also call the telephone number on your ID card.
- Any product dispensed for the purpose of appetite suppression or weight loss when prescribed solely for the purposes of losing weight. This exclusion does not apply to outpatient prescription drugs prescribed for the Medically Necessary treatment of morbid obesity for which Benefits are provided as described under Obesity - Weight Loss Surgery in Section 1of the COC.
- Medications used for cosmetic purposes.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. However, this does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter. Certain Prescription Drug Products that are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously limited under this provision. 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 as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1: Covered Health Care Services. This 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.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of a health condition, except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC.

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

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

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

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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