

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 Non-Differential Options PPO Plan?

Coverage is available no matter what doctor or hospital you use.

You can use any doctor, clinic, hospital or health care facility in the country.

- > **You'll have the same level of coverage for any health care provider or facility you use.** If you can, use doctors and hospitals in the network. They can help keep your costs low.
- > **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? Learn more about this plan and search for network doctors or hospitals at welcometouhc.com/nondiffppo 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-insurance	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
30%	\$2,250	30%

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

Your Costs

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

Your cost for all 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.

- > 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	\$2,250 per year
Medical Deductible - Family	\$4,500 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	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.

- > 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	\$7,350 per year
Out-of-Pocket Limit - Family	\$14,700 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. Service site review may be a component of the prior authorization process.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

This offer is being issued under UHCBPCA. Select, Choice and Core products are Pending Regulatory Approval.

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 for all Benefits
Acupuncture Services	30% co-insurance, after the medical deductible has been met.
Ambulance Services	30% co-insurance, after the medical deductible has been met.
Non-Emergency Ambulance:	30% co-insurance, after the medical deductible has been met. 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	The amount you pay is based on where the covered health care service is provided.
Cellular or Gene Therapy services must be received from a Designated Provider.	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.
Congenital Heart Disease (CHD) Surgeries	Benefits will be the same as stated under Hospital - Inpatient Stay.
Dental Anesthesia	30% co-insurance, after the medical deductible has been met.
Dental - Pediatric Services (Benefits covered up to age 19)	Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).

Your Costs

Covered Health Care Services

Your cost for all Benefits

Dental - Pediatric Preventive Services

Dental Prophylaxis (Cleanings) Limited to 1 time every 6 months.	You pay nothing. A deductible does not apply.
Fluoride Treatments Limited to 1 time every 6 months.	You pay nothing. 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.
Space Maintainers (Spacers) Limited to once per provider, per quadrant or arch per lifetime.	You pay nothing. 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.
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.

Your Costs

Covered Health Care Services

Your cost for all Benefits

Dental - Pediatric Basic Dental Services

Endodontics (Root Canal Therapy) 20% co-insurance, after the medical deductible has been met.

Adjunctive Services 20% co-insurance, after the medical deductible has been met.

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.

Oral Surgery 20% co-insurance, after the medical deductible has been met.

Periodontics 20% co-insurance, after the medical deductible has been met.

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.

Minor Restorative Services (Amalgam or Anterior Composite) 20% co-insurance, after the medical deductible has been met.

Multiple restorations on one surface will be treated as a single filling and limited to 1 per tooth per 12 months.

Simple Extractions (Simple tooth removal) 20% co-insurance, after the medical deductible has been met.

Limited to one time per tooth per lifetime.

Dental - Pediatric Major Restorative Services

Crowns/Inlays/Onlays 50% co-insurance, after the medical deductible has been met.

Limited to one time per tooth every 60 months.

Removable Dentures 50% co-insurance, after the medical deductible has been met.

(Full denture/partial denture)

Limited to a frequency of one every 60 months.

Bridges (Fixed partial dentures) 50% co-insurance, after the medical deductible has been met.

Limited to one time every 60 months.

Implant Procedures 50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost for all 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.

Prior Authorization is required for orthodontic treatment.

Dental Services and Oral Surgery- Accident Only

30% co-insurance, after the medical deductible has been met.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:

You pay nothing. A deductible does not apply.

For Self-Management and Training, cost sharing will not exceed the costs for Physician office visit.

Prior Authorization is required for DME 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 care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Schedule of Benefits.

Durable Medical Equipment (DME), Orthotics and Supplies

30% 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

30% co-insurance, after the medical deductible has been met.

Enteral Formula and Amino Acid-Modified Food Products (Medical Foods)

30% co-insurance, after the medical deductible has been met.

Fertility Preservation for Iatrogenic Infertility

30% co-insurance, after the medical deductible has been met.

Gender Dysphoria

The amount you pay is based on where the covered health care service is provided.

Your Costs

Covered Health Care Services

Your cost for all Benefits

Habilitative Services and Manipulative Treatments

Inpatient: The amount you pay is based on where the covered health care service is provided.

Outpatient: 30% co-insurance, after the medical deductible has been met.

Outpatient therapies are limited per year as follows:

24 Manipulative Treatments.

Prior Authorization is required for certain Inpatient services.

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.

30% 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.

30% co-insurance, after the medical deductible has been met.

Prior Authorization is required.

Hospice Care

30% co-insurance, after the medical deductible has been met.

Prior Authorization is required for Inpatient Stay.

Hospital - Inpatient Stay

30% co-insurance, after the medical deductible has been met.

Prior Authorization is required.

Your Costs

Covered Health Care Services

Your cost for all 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 and medically necessary Iatrogenic Fertility Preservation as described under Fertility Preservation for Iatrogenic Infertility.

30% co-insurance, after the medical deductible has been met.

Prior Authorization is required.

Lab, X-Ray and Diagnostic - Outpatient

Lab Testing - Outpatient:

30% co-insurance, after the medical deductible has been met.

X-Ray and Other Diagnostic Testing - Outpatient:

30% co-insurance, after the medical deductible has been met.

Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.

Major Diagnostic and Imaging - Outpatient

30% 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:

30% co-insurance, after the medical deductible has been met.

Outpatient Office Visits:

30% co-insurance, after the medical deductible has been met.

All Other Outpatient Treatment:

30% 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 for all Benefits

Obesity - Weight Loss Surgery

For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.

30% co-insurance, after the medical deductible has been met.

Prior Authorization is required.

Off-Label Drug Use and Experimental or Investigational Services

The amount you pay is based on where the covered health care service is provided.

Osteoporosis Services

The amount you pay is based on where the covered health care service is provided.

Ostomy and Urological Supplies

30% 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.

30% co-insurance, after the medical deductible has been met.

Applies to drugs administered by a provider on an outpatient basis in a Hospital, Alternate Facility or Physician's office.

Phenylketonuria (PKU) Treatment

30% co-insurance, after the medical deductible has been met.

Prior Authorization is required.

Physician Fees for Surgical and Medical Services

30% co-insurance, after the medical deductible has been met.

Physician's Office Services - Sickness and Injury

30% co-insurance for a primary care physician office visit, after the medical deductible has been met.

30% co-insurance for a specialist office visit, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost for all Benefits

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.

All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care act, will be provided without cost share. Please refer to Preventive Care Services.

The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

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.

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 and other Preventive Services. You pay nothing. A deductible does not apply.

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

30% 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 per year as follows:
24 Manipulative Treatments.

30% 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.

30% co-insurance, after the medical deductible has been met.

Skilled Nursing Facility / Inpatient Rehabilitation Facility Services (Including Habilitative

Your Costs

Covered Health Care Services

Your cost for all Benefits

Services During an Inpatient Stay)

Limited to 100 days per benefit period for Skilled Nursing Facility. 30% co-insurance, after the medical deductible has been met.

Prior Authorization is required.

Specialized Footwear

30% co-insurance, after the medical deductible has been met.

Surgery - Outpatient

30% 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. 30% co-insurance, after the medical deductible has been met.

Prior Authorization is required for certain services.

Transplantation Services

The amount you pay is based on where the covered health care service is provided.

Prior Authorization is required.

Urgent Care Center Services

30% co-insurance, after the medical deductible has been met.

Urinary Catheters

30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost for all Benefits

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 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.

30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost for all 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 You pay nothing. A deductible does not apply.
Limited to once every 12 months.

Eyeglass Lenses 30% co-insurance. A deductible does not apply.
Limited to once every 12 months.

Lens Extras You pay nothing. A deductible does not apply.
Limited to once every 12 months.
Coverage includes polycarbonate lenses and standard scratch-resistant coating.

Eyeglass Frames 30% co-insurance. A deductible does not apply.
Limited to once every 12 months.

Contact Lenses/Necessary Contact Lenses 30% co-insurance. A deductible does not apply.

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.

Low Vision Care Services

Low Vision Comprehensive Evaluation You pay nothing for Low Vision Comprehensive Evaluation. A deductible does not apply.

Limited to once every 24 months.

Low Vision Follow-up Care You pay nothing for Low Vision Follow-up Care. A deductible does not apply.
Limited to four visits in any 5 year period.

Low vision aid such as high-power spectacles, magnifiers and telescopes. 25% co-insurance for Low Vision aid such as high-power spectacles, magnifiers and telescopes. A deductible does not apply.

Limited to once every 12 months.

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 per calendar year. 30% co-insurance. A deductible does not apply.

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

For Internal Use only:

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UnitedHealthcare Benefits Plan of California 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。

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

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

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

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

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेवाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្រវាជន្តិយភាសាដើរយតតតិតថ្ងៃ គឺមានស្តាប់អ្នក។ សមនូវសព្វទៅលេខតតតិតថ្ងៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániti'go, saad bee áka'anida'awo'igíí, t'áá jíik'eh, bee ná'ahóot'i'. T'áá shqoqí ninaaltsoos nit'i'izi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh bee hane'í biká'igíí 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.

Outpatient Prescription Drug Products

California Plan C33

Standard Drugs: 20/50/100/25%

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

Individual Deductible	\$200 (Deductible does not apply to Tier 1)
Family Deductible	\$400 (Deductible does not apply to Tier 1)

Out-of-Pocket Drug Limit

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.

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 the Certificate of Coverage, the Certificate of Coverage shall prevail.

Tier Level	Up to 31-day supply	Up to 90-day supply
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	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	Retail Non-Preferred Specialty Network Pharmacy	*Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy**
Tier 1 Prescription Drug Products	\$20	\$20	\$50
Tier 2 Prescription Drug Products	\$50	\$50	\$125
Tier 3 Prescription Drug Products	\$100	\$100	\$250
Tier 4 Prescription Drug Products	25% however you will not pay more than \$250	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.

** You will be charged a retail Co-payment and/or Co-insurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Other Important Information about your Outpatient Prescription Drug Benefits

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

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

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, no Benefits will be paid 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.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications.

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.

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.

PHARMACY EXCLUSIONS

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

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available over-the-counter are not covered except when Medically Necessary. Certain prescription drug products that are Therapeutically Equivalent to over the counter drugs or supplement are not covered unless Medically Necessary and Prior Authorized.
- Experimental or Investigational medications; medications used for experimental are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section 1 of the COC.
- Any product dispensed for the purpose of appetite suppression or weight loss for non-medical conditions.
- Medications used for cosmetic purposes.
- Certain Prescription Drug Products for tobacco cessation unless they are FDA-approved tobacco cessation drugs and required to be covered under the Patient Protection and Affordable Care Act (PPACA) in order to comply with essential health benefits requirements.
- 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. Generally over-the-counter Drugs are excluded whether prescribed or not unless they are on UnitedHealthcare's PDL or unless they are FDA-approved tobacco cessation drugs and products, or FDA-approved contraceptives, drugs, devices or other products both of which are provided as preventive benefit at \$0 cost sharing subject to certain exception. This exclusion does not apply to prescribed over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a provider for which Benefits are available, without cost sharing, as described under Section 1 of the COC. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Network Physician provided that the diet is Medically Necessary. This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).

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Standard/Sep/Custom Advantage (state mandated)/47670/2018

UnitedHealthcare Benefits Plan of California 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。

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

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

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

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

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(**Japanese**)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) ស្រីវាជំនួយភាសាដើរយតតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សមន្ទវសព្វទៅលើខតតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

DÍI BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i. T'áá shq'odi ninaaltsoos nít'izi bee nééhoziniigíí bine'déé' t'áá jíik'ehgo béésh bee hane'i 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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