UnitedHealthcare®

Benefit Summary

Select Plus PPO
California - Select Plus
Traditional with Deductible - Plan PR3 Mod

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	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
$20	$1,000	30%

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	$1,000 per year	$1,000 per year
Medical Deductible - Family	$3,000 per year	$3,000 per year
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	$4,000 per year	$6,000 per year
Out-of-Pocket Limit - Family	$12,,000 per year	$18,000 per year

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.

Product forms included herein are subject to approval by regulators. If the product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and if necessary 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
Ambulance Services		
Emergency Ambulance	30% co-insurance, after the medical deductible has been met.	30% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Breast Cancer Services		
	The amount you pay is based on where the covered health care service is provided.	
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		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Dental Anesthesia Services		
Limited to Covered Persons who are one of the following: a child under seven years of age; a person who is developmentally disabled regardless of age; a person whose health is compromised and for whom general anesthesia is required, regardless of age.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Dental Services - Accident Only		
	30% co-insurance, after the medical deductible has been met.	30% co-insurance, after the network medical deductible has been met.
	Prior Authorization is required.	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
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider.	
		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. Benefits for diabetes supplies will be the same as those stated in the Outpatient Prescription Drug Rider.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Durable Medical Equipment (DME), Orthotics and Supplies		
Limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	30% co-insurance, after the medical deductible has been met.	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		
	$100 co-pay per visit. A deductible does not apply.	$100 co-pay per visit. 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
Gender Dysphoria		
Inpatient:	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient Office Visits:	$30 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
All Other Outpatient Office Visits:	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient prescription drugs for the treatment of gender dysphoria are subject to the cost share as noted in the Outpatient Prescription Drug Schedule of Benefits.		
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.	$30 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Hearing Aids		
Limited to $2,500 every year. 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.	50% 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
Home Health Care		
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. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Major Diagnostic and Imaging - Outpatient		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Mastectomy Services		
	The amount you pay is based on where the covered health care service is provided.	

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
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 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.	
Osteoporosis Services		
	The amount you pay is based on where the covered health care service is provided.	
Ostomy Supplies		
	30% co-insurance, after the medical deductible has been met.	50& co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	30% co-insurance, after the medical deductible has been met.	50& co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) Treatment		
	30% co-insurance, after the medical deductible has been met.	50& co-insurance, after the medical deductible has been met. Prior Authorization is required.
Physician Fees for Surgical and Medical Services		
	30% co-insurance, after the medical deductible has been met.	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
Physician's Office Services		
	$20 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.		
Pregnancy - Maternity Services		
We pay for Covered Health 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 below.	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 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. 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		
	You pay nothing. A deductible does not apply.	Out-of-Network Benefits are not available.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prosthetic Devices		
	30% co-insurance, after the medical deductible has been met.	50& co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Prosthetic Devices - Laryngectomy		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
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: 20 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 24 visits of Manipulative Treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of pervasive developmental disorder or Autism Spectrum Disorders.	$20 co-pay per visit. A deductible does not apply.	50& co-insurance, after the medical deductible has been met.
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.	50& 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
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	30% co-insurance, after the medical deductible has been met.	50& co-insurance, after the medical deductible has been met. Prior Authorization is required.
Surgery - Outpatient		
	30% co-insurance, after the medical deductible has been met.	50& co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telehealth Services		
	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services		
Covered Health Care Services are payable in the same manner as surgery for other medical conditions.	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.	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		
	$20 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.

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.	$20 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available.
Vision Exams		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 24 months.	$20 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available.

Services your plan does not cover (Exclusions)

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

Alternative Treatments

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

Dental

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

Devices, Appliances and Prosthetics

Devices used as safety items or to help performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to help in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC and speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Oral appliances for snoring. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

The following exclusions apply only to prescription drug products and Pharmaceutical Products covered under the medical Benefits described in this Certificate. These exclusions do not apply to prescription drug products covered under the Outpatient Prescription Drug Rider. Prescription drug products for use outside of a healthcare setting that are filled by a prescription order or refill (i.e. a supply of prescription drug products for home/personal use). This exclusion does not apply if the Policy includes an Outpatient Prescription Drug Rider. Self-injectable medications, except those needed to treat diabetes. This exclusion does not apply to medications which, due to their traits, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications that are covered under the Outpatient Prescription Drug Rider. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments that are covered under the Outpatient Prescription Drug Rider. 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 1of the COC. Growth hormone therapy for non-FDA approved uses only. This exclusion does not apply to growth hormone therapy that is covered under the Outpatient Prescription Drug Rider. Certain Pharmaceutical Products and not covered unless they are prescribed by a Specialist.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational Services and Unproven Services are excluded except Benefits provided for clinical trials for cancer or other Life-Threatening disease or condition and for Experimental or Investigational Services and Unproven Services as defined under Section 9 of the COC and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a Chronic and Seriously Debilitating or Life-Threatening condition. The drug must appear on the formulary list, when it is prescribed off-label for the treatment of a Chronic and Seriously Debilitating condition. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the American Hospital Formulary Service's Drug Information; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium or Thomson Micromedex DrugDex; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC. This exclusion does not apply to Behavioral Health Treatment for pervasive developmental disorder or Autism Spectrum Disorder.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes (this exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC); shoe orthotics; shoe inserts (this exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC) and arch supports.

Services your plan does not cover (Exclusions)

Medical Supplies and Equipment

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

- Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC.
- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices in Section 1 of the COC. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks except when used with DME as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance - Related and Addictive Disorders

Services performed in connection with conditions not classified as mental disorders in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. This exclusion will not affect or reduce any obligation to provide services for Severe Mental Illness, Serious Emotional Disturbances, pervasive developmental disorder or Autism Spectrum Disorders as required by California law. Transitional Living services.

Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or diabetes medical nutrition therapy. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula and donor breast milk except as described under phenylketonuria (PKU) Treatment in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes except as described under phenylketonuria (PKU) Treatment in Section 1 of the COC.

Personal Care, Comfort or Convenience

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

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. This exclusion does not apply to Reconstructive Procedures in Section 1 of the COC. Examples of Cosmetic Procedures include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Treatment of benign gynecomastia (abnormal breast enlargement in males). This exclusion does not apply to the reconstructive and Medically Necessary treatment of benign gynecomastia for male patients. This exclusion does not apply to reconstructive surgery when gynecomastia is caused by disease. Physical conditioning programs such as athletic training, body-building, exercise, fitness or flexibility. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. This exclusion does not apply to intensive behavioral interventions for which Benefits are provided as described under Preventive Care Services in Section 1 of the COC. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. This exclusion does not apply to Reconstructive Procedures in Section 1 of the COC. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in Temporomandibular Joint (TMJ) Services under Section 1 of the COC. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under Other Health Education Services for You in the section of the COC titled Our Responsibilities. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under Preventive Care Services in Section 1 of the COC. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. This exclusion does not apply to any other reconstructive surgery necessary to create a normal appearance for the gender with which you identify as described under Gender Dysphoria in Section 1 of the COC. Helicobacter pylori (H. pylori) serologic testing.

Providers

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

Services your plan does not cover (Exclusions)

Reproduction

Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, or similar legislation. This exclusion only applies when you are legally entitled to such other coverage and you are able to receive health services under the other coverage arrangement. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health care services during active military duty, when you are on active duty for more than 30 days.

Transplants

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

Travel

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

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care aides. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Cost and fitting charge for eyeglasses and contact lenses. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: You have craniofacial anomalies in which normal or absent ear canals prevent the use of a wearable hearing aid: or You have hearing loss of sufficient severity that it cannot be remedied enough by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following: Medically Necessary; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when: required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders. (This exclusion does not apply to services that are determined to be Medically Necessary). Conducted for purposes of medical research (This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to get or maintain a license of any type. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in the United States or in non-war zones outside of the United States. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy. Charges in excess of the Allowed Amount or in excess of any specified limitation. This exclusion does not apply when we arrange access to medically appropriate care from a qualified out-of-Network provider if medically appropriate care cannot be provided within the Network. You will only be responsible for paying cost-sharing in an amount equal to the cost-sharing you would have paid for provision of that or a similar service in-Network. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services that are Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

For Internal Use only:
CAMAD06PR318

Item#	**Rev. Date**	
400-11224	0319_rev09	Base/Value/Sep/Emb/33149/2018

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。

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 معرّف 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)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल 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: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានចារើលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

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

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