UnitedHealthcare®

Benefit Summary

Choice Plus Gold 750
Virginia - Choice Plus
Choice Plus Direct - Plan BO4V

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 UnitedHealthcare Choice Plus Direct Plan?

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

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

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

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

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

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

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

Are you a member?

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

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

Benefits At-A-Glance

What you may pay for network care

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

Co-payment	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	$750	20%

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 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 do not 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.		
> This benefit plan includes a per occurrence deductible that applies to certain covered health care services. This per occurrence deductible must be met prior to and in addition to the medical deductible.		
Medical Deductible - Individual	$750 per year	$2,000 per year
Medical Deductible - Family	$1,500 per year	$4,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.	Included in your medical deductible.
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The 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, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$7,500 per year	$15,000 per year
Out-of-Pocket Limit - Family	$15,000 per year	$30,000 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. When prior authorization is the responsibility of a Network provider, any reduction or denial of benefits will not affect you. 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.

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:	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.	40% 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.
Cellular and Gene Therapy		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Chiropractic Osteopathic / Manipulation Services		
Limited to 30 visits per year. Applies separately for rehabilitative and habilitative services for spinal manipulations and other manual medical interventions.	$20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Cleft Lip and Cleft Palate Treatment		
	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.
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 Defects and Birth Abnormalities		
	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.
Congenital Heart Disease (CHD) Surgeries		
	Benefits will be the same as stated under Hospital - Inpatient Stay.	
		Prior Authorization is required.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Anesthesia and Facility Services		
	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.
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Space Maintainers (Spacers)	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Dental - Pediatric Diagnostic Services		
Evaluations (Check-up Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing, after the medical deductible has been met.	You pay nothing, 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
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Adjunctive Services Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General Anesthesia: Covered only when clinically Necessary. Occlusal Guard: Limited to one guard every 12 months.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Oral Surgery	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to one per two years per quadrant. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite)	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Dental - Pediatric Major Restorative Services		
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	50% 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
Dental - Pediatric Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for orthodontic treatment.	Prior Authorization is required for orthodontic treatment.
Dental Services - Accident Only		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
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 and in the Outpatient Prescription Drug Amendment.	
		Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for DME or orthotics that costs more than $1,000.
Early Intervention Services		
	The amount you pay is based on where the covered health care service is provided.	
Emergency Health Care Services - Outpatient		
	After you pay the $250 per occurrence deductible per visit; you pay 20% co-insurance, after the medical deductible has been met.	After you pay the $250 per occurrence deductible per visit; you pay 20% co-insurance, after the network medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Amendment.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Habilitative Services		
Inpatient:	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies are limited per year as follows: 30 visits for any combination of physical or occupational therapy. 30 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. The limits for physical, occupational and speech therapy will not apply if you get that care as part of the Hospice Care benefit. When you get physical, occupational or speech therapy in the home, the home health care visit limit will apply instead of the therapy services limit listed above.	$20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
		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.	20% co-insurance, after the medical deductible has been met.	40% 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
Home Health Care		
Limited to 100 visits per year for Home Health Care. 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 Network provider. This home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits. This home health care limit does not apply to home infusion therapy or home dialysis. In accordance with Virginia law and as described in the Certificate of Coverage, Benefits are provided for home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital. Such visits are not subject to the above annual limits.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Home Treatment of Hemophilia and Congenital Bleeding Disorders		
Benefits for blood infusion equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment (DME), Orthotics and Supplies.	The amount you pay is based on where the covered health care service is provided for blood infusion equipment and blood products, and will be the same as those stated under Durable Medical Equipment, Pharmaceutical Products - Outpatient, or in the Outpatient Prescription Drug Amendment.	Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Hospice Care		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	Designated Network: You pay nothing. A deductible does not apply. Network: 20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	20% co-insurance, after the medical deductible has been met.	40% 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		
	20% co-insurance, after the medical deductible has been met for services provided at a freestanding diagnostic center or in a physician's office. After you pay the $250 per occurrence deductible per service; you pay 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.	40% co-insurance, after the medical deductible has been met for services provided at a freestanding diagnostic center or in a physician's office. 40% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center. Prior Authorization is required.
Medical Formulas		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Outpatient:	$40 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.
Oral Surgery		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Ostomy and Urologic Supplies		
	20% co-insurance, after the medical deductible has been met.	40% 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.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	$20 co-pay per visit for a primary care physician office visit. A deductible does not apply. $40 co-pay per visit for a specialist office visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
In accordance with Virginia law, Benefits are provided for certain home visits for mothers following obstetrical care in a Hospital, as prescribed by a Physician.	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		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
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		
Limited to 1 wig per year for cancer treatment.	20% co-insurance, after the medical deductible has been met.	40% 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.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Rehabilitation Services - Outpatient Therapy		
Limited to: 30 visits for any combination of physical therapy or occupational therapy. 30 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. Unlimited visits for pulmonary and cardiac rehabilitation therapy. The limits for physical, occupational, and speech therapy will not apply if care is part of the Hospice Care benefit. When you get physical, occupational, or speech therapy, or cardiac rehabilitation in the home, the home health care visit limit will apply instead of the therapy services limits listed above.	$20 co-pay per visit. A deductible does not apply.	40% 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.	20% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office. After you pay the $250 per occurrence deductible per date of service; you pay 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.	40% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office. 40% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 100 days per Inpatient stay.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Surgery - Outpatient		
	20% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. After you pay the $250 per occurrence deductible per date of service; you pay 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.	40% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. 40% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center. Prior Authorization is required for certain services.
Temporomandibular Joint 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.	20% co-insurance, after the medical deductible has been met.	40% 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.	Prior Authorization is required.
Urgent Care Center Services		
	$20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

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 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.	$10 co-pay per visit. A deductible does not apply.	40% 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
Vision - Pediatric Services (Benefits covered up to age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Routine Vision Exam Limited to once per year.	$20 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass Lenses Limited to once per year.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Lens Extras Limited to once per year. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.	You pay nothing, after the medical deductible has been met.
Eyeglass Frames Limited to once per year.		
Eyeglass frames with a retail cost up to $130.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $130 - 160.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $160 - 200.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $200 - 250.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than $250.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/ or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Low Vision Care Services Limited to once every 24 months.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.	25% co-insurance for Low Vision Testing, after the medical deductible has been met. 25% co-insurance for Low Vision Therapy, 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
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 year.	$20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.

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

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

For Internal Use only:

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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

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

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UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug Products

Virginia Plan 827

Standard Drugs: 10/40/75 Specialty Drugs: 10/250/500

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 or Tier 3. 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 Deductible	
Individual Deductible	See Medical Benefit Summary
Family Deductible	See Medical Benefit Summary
Out-of-Pocket 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.

A deductible and out-of-pocket limit may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket limit amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your co-payment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the co-payments outlined below. If you reach the out-of-pocket limit, you will not be required to pay a co-payment.

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 Outpatient Prescription Drug Amendment and 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 Outpatient Prescription Drug Amendment or the Certificate of Coverage, the Outpatient Prescription Drug Amendment and Certificate of Coverage shall prevail.

Tier Level	Up to 31-day supply		Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	**Retail Non-Preferred Specialty Pharmacy**	***Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy****
Tier 1 Prescription Drug Products	**$10**	**Not Applicable**	**$20**
Tier 1 Specialty Prescription Drug Products	**$10**	**$20**	**Not Covered*****
Tier 2 Prescription Drug Products	**$40**	**Not Applicable**	**$80**
Tier 2 Specialty Prescription Drug Products	**$250**	**$500**	**Not Covered*****
Tier 3 Prescription Drug Products	**$75**	**Not Applicable**	**$150**
Tier 3 Specialty Prescription Drug Products	**$500**	**$1000**	**Not Covered*****

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.

For Specialty Drugs from a Non-Preferred Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.

*** Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Amendment.

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

Other Important Information about your Outpatient Prescription Drug Benefits

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment 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 or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment 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, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty 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 Amendment 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 some 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 Pharmacy, you may be subject to the Non-Preferred Specialty Co-payment or Co-insurance. If, however, a non-Designated Pharmacy has notified us or our intermediary that it agrees to accept reimbursement at the rate applicable to a Designated Pharmacy as payment in full, it may be possible to receive Benefits on the same basis and at the same cost-share as you would from a Designated Pharmacy. The non-Designated Pharmacy must, if requested to do so in writing by us or our intermediary, execute and deliver to us or our intermediary, within 30 days of the pharmacy's receipt of our request, the Network provider agreement which we require of all Designated Pharmacies. Any non-Designated Pharmacy which fails to timely execute and deliver such agreement will continue to be treated as a non-Designated Pharmacy with respect to Benefits unless and until the pharmacy executes and delivers the agreement.

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 some Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at myuhc.com® or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

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

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

PHARMACY EXCLUSIONS

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

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used for cosmetic purposes.
- Prescription Drug Products when prescribed to treat infertility.
- Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs 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. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- 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. This exclusion does not apply to Medical Formulas for the treatment of inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies when prescribed by a Physician and deemed Medically Necessary to maintain adequate nutritional status.

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.

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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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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.welcometouhc.com or by calling 1-800-782-3740. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $750 Individual / $1,500 Family out-of-Network: $2,000 Individual / $4,000 Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $7,500 Individual / $15,000 Family out-of-Network: $15,000 Individual / $30,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-800-782-3740 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit, deductible does not apply	40% coinsurance	Virtual visits (Telehealth) - $10 copay per visit by a Designated Virtual Network Provider, deductible does not apply. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$40 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/immunization	No Charge	40% coinsurance	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing/Office: 20% coinsurance . Hospital: 20% coinsurance .	Free standing/Office: 40% coinsurance , Hospital: 40% coinsurance .	Preauthorization required for out-of-Network for certain services or benefit reduces to 50% of allowed. Designated Network Lab - No Charge
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: 20% coinsurance . Hospital: 20% coinsurance .	Free standing/Office: 40% coinsurance , Hospital: 40% coinsurance	$250 Hospital-Based per occurrence deductible applies prior to the overall deductible. Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: $10 copay Mail-Order: $20 copay Specialty Drugs**: $10 copay	Deductible does not apply. Retail: $10 copay Specialty Drugs: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply or *Preferred 90 Day Retail Network Pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. **Your cost shown is for a Preferred Specialty Network Pharmacy. Non-Preferred Specialty Network Pharmacy: Copay is 2 times the Preferred Specialty Network Pharmacy Copay or the coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $40 copay Mail-Order: $80 copay Specialty Drugs**: $250 copay	Deductible does not apply. Retail: $40 copay Specialty Drugs: $250 copay	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $75 copay Mail-Order: $150 copay Specialty Drugs**: $500 copay	Deductible does not apply. Retail: $75 copay Specialty Drugs: $500 copay	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center: 20% coinsurance Hospital: 20% coinsurance	Ambulatory Surg Center: 40% coinsurance , Hospital: 40% coinsurance	Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed. $250 Hospital-based per occurrence deductible applies prior to the overall deductible.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	$250 Emergency per occurrence deductible applies prior to the overall deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay per visit, deductible does not apply	40% coinsurance	Network partial hospitalization /intensive outpatient treatment: 20% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Inpatient preauthorization apply for out-of-Network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per calendar year. Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	$20 copay per outpatient visit, deductible does not apply	40% coinsurance	Limits per calendar year Physical and Occupational: 30 visits combined; Speech: 30 visits; Pulmonary and Cardiac: Unlimited.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$20 copay per outpatient visit, deductible does not apply	40% coinsurance	Limits per calendar year: Physical and Occupational: 30 visits combined; Speech: 30 visits. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit to 50% of allowed.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing is limited to 100 days per calendar year (combined with Inpatient Rehabilitation) . Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization required for out-of-Network Durable medical equipment over $1,000 or no coverage.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required for out-of-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	$20 copay per visit, deductible does not apply	50% coinsurance	One exam every 12 months.
	Children's glasses	50% coinsurance, deductible does not apply	50% coinsurance	One pair every 12 months.
	Children's dental check-up	0% coinsurance	0% coinsurance	Cleanings covered 2 times per 12 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery	• Dental Care (Adult)	• Infertility Treatment
• Long-Term Care	• Non-emergency care when traveling outside the U.S.	• Routine Foot Care	• Weight Loss Programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Chiropractic care-30 visits per calendar year	• Hearing Aids-$2,500/ calendar year	• Private Duty Nursing - 2 visits/calendar year	• Routine eye care (Adult)-1 exam/12 months

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration. You may also contact us at 1-800-782-3740 . Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-782-3740 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Virginia Bureau of Insurance at 1-877-310-6560 or www.scc.virginia.gov/boi.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-782-3740 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740 .
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-782-3740 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3740 .

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$ 750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$700
Copayments	$30
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,890

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$ 750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$1,530

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$ 750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$700
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$900

The plan would be responsible for the other costs of these EXAMPLE covered services

Notice of Non-Discrimination

We do 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 the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, 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 number listed within this Summary of Benefits and Coverage (SBC), 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 other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

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 ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث العربية **(Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

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 nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री 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 dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកត់ចេញថ្លៃ ដែលមានកត់នៅក្តាង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

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 Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' 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 bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).