UnitedHealthcare®

Benefit Summary

Choice Plus Gold 3200
Missouri - Choice Plus
Balanced - Plan AUCN

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 Choice 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? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** 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)
$35	$3,200	20%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), 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	$3,200 per year	$6,400 per year
Medical Deductible - Family	$6,400 per year	$12,800 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 and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$5,000 per year	$10,000 per year
Out-of-Pocket Limit - Family	$10,000 per year	$20,000 per year

Your Costs

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

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. Prior Authorization is required for Non-Emergency Ambulance.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder Treatment		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for Autism Spectrum Disorders Treatment during a Physician's office visit will be the same as found under Physician's Office - Sickness and Injury in this Benefit Summary. Benefits for Therapeutic Treatments for Autism Spectrum Disorders will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary.	
		Prior Authorization is required.
Chiropractic Services		
Co-insurance will not exceed 50% of the total cost of any single chiropractic service provided within the scope of a chiropractor's license as defined by Missouri law.	50% co-insurance. A deductible does not apply.	50% co-insurance. A deductible does not apply.
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 Surgeries		
	Benefits will be the same as stated under Hospital - Inpatient Stay.	
		Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Anesthesia and Facility Charges		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for dental anesthesia received on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under Physician Fees for Surgical and Medical Services in this Benefit Summary.	
		Prior Authorization is required.
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 20 Network (PPO-MAC).		
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.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	20% co-insurance, 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 every 36 months per surgical area. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis.	20% co-insurance, 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.

Your Costs

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.
	Prior Authorization is required.	Prior Authorization is required.
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.
Durable Medical Equipment (DME), Orthotics and Supplies		
Coverage is provided for orthotic devices.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for 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. Examples include but are not limited to the following: Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for early intervention services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for early intervention services that are considered rehabilitation services will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary.	
		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
Emergency Health Care Services - Outpatient		
	20% co-insurance after you pay the $300 co-pay per visit. A deductible does not apply.	20% co-insurance after you pay the $300 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Gender Dysphoria		
	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.
Habilitative Services		
Inpatient: Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are limited to 150 days per year.	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies are limited per year as follows: 25 visits of physical therapy. 25 visits of occupational therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive therapy. Limits do not apply to Therapeutic Care for the Treatment of Autism Spectrum Disorder or Early Intervention Services.	$35 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		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Hearing Screening for Newborns		
	You pay nothing. A deductible does not apply.	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.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Human Leukocyte Testing		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for laboratory tests related to human leukocyte testing will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for human leukocyte testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient	20% co-insurance, after the medical deductible has been met.	50% 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.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Major Diagnostic and Imaging - Outpatient		
	$400 co-pay per service. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Medical Foods		
	20% 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
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
	20% 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.	20% co-insurance, after the medical deductible has been met.	50% 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.	50% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	$35 co-pay per visit for a primary care physician office visit. A deductible does not apply. $70 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 Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.		
Pregnancy - Maternity Services		
	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.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests. You are not required to pay any Co-payments or Co-insurance or meet any deductible for immunizations for Enrolled Dependent children from birth to age five.	You pay nothing. A medical deductible does not apply.	50% 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.		
Private Duty Nursing		
Limited to 82 visits per year, 164 visits during the entire period you are covered under this Policy.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Prosthetic Devices		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	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
Rehabilitation Services - Outpatient Therapy		
Limited to: 36 visits of cardiac rehabilitation therapy. 25 visits of physical therapy. 25 visits of occupational therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. Limits do not apply to Therapeutic Care for the Treatment of Autism Spectrum Disorder or Early Intervention Services.	$35 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 150 days per year.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Speech and Hearing Services		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for speech and hearing therapy related to rehabilitation will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for speech and hearing services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under Lab, X-ray and Diagnostics - Outpatient in this Benefit Summary.	
Surgery - Outpatient		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Telehealth		
	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular/Craniomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health care service is provided.Examples include but are not limited to the following: Benefits for temporomandibular/craniomandibular joint services received during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for temporomandibular/craniomandibular joint services during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary.	
		Prior Authorization is required.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received 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		
	$50 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. 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.	$10 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Routine Vision Exam Limited to once every 12 months.	$10 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass Lenses Limited to once every 12 months.	$25 co-pay. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.	You pay nothing, after the medical deductible has been met.
Eyeglass Frames Limited to once every 12 months.		
Eyeglass frames with a retail cost up to $130.	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $130 - 160.	$15 co-pay. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $160 - 200.	$30 co-pay. 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-pay. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than $250.	40% 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.	$25 co-pay. 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 Examination (Benefit is for Covered Persons over age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 12 months.	$10 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Voluntary Sterilizations		
	The amount you pay is based on where the covered health care service is provided.	
Wigs		
Limited to the first wig following cancer treatment, not to exceed one per year.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

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

Alternative Treatments

Acupressure; 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 Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Autism Spectrum Disorders Treatment

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational services that are focused on mainly building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under Autism Spectrum Disorders Treatment in Section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions shown in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Transitional Living services.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia, except as described under Dental Anesthesia and Facility Charges 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 acute traumatic Injury, cancer or cleft palate, diseases of the mouth and if injury to the tooth was a serious injury as described under Dental Services - Accident Only in Section 1 of the COC. 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; and services to improve dental clinical outcomes. 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). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Services your plan does not cover (Exclusions)

Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. Any Dental Procedure not directly related with dental disease. Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Rider to the Policy. Dental Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy ends. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child. Foreign Services are not covered unless required as an Emergency. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO). Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

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. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses (this exclusion does not apply to trusses described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC), and ultrasonic nebulizers. Devices and computers to help in communication and speech except for 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. This exclusion does not apply to assistive technology devices for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431. 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

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. 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. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care Covered Healthcare Services considered medically necessary under 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. Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes. Arch supports.

Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

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:

- 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 Services 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 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. This exclusion does not apply to Benefits described under Autism Spectrum Disorders Treatment in Section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions shown in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act. 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. 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. This exclusion does not apply to enteral formulas for which Benefits are provided as described under Medical Foods 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. This exclusion does not apply to enteral formulas for which Benefits are provided as described under Medical Foods 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); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness or flexibility. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs except when provided following cancer treatment.

Procedures and Treatments

Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. 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. Rehabilitation services and Chiropractic Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment. This does not apply to Autism Spectrum Disorder. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary for long term or progressive conditions such as following a post-traumatic brain Injury, cerebral vascular accident, cerebral palsy, Alzheimer's disease, Parkinson's disease or stroke. Psychosurgery. 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. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. 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. 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.

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.

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 your plan does not cover (Exclusions)

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. Examples include coverage required by workers' compensation, no fault auto insurance or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. 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 for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health care services during active military duty.

Transplants

Health care services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. 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 as determined by us. 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. 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. This exclusion does not apply to vision correction after surgery for which Benefits are provided as described under Vision Correction After Surgery in Section 1 of the COC. 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.

Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the COC. Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Optional Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services.

Services your plan does not cover (Exclusions)

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 we determine to be all of the following: Medically Necessary; described as a Covered Health Care Service in Section 1 of the COC and Schedule of Benefits; 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 non-war zones. 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. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to Section 4 of the COC. 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. In the event an out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the co-payments, co-insurance and/or deductible are waived. Charges in excess of the Allowed Amount or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider. 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 we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service. This exclusion does not apply to services covered under Emergency Health Care Services. 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:
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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

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 ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá 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.