



Open Enrollment

Ready to dive in?

Here we go.

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Welcome.

Find out how to get the most out of your health plan.

United
Healthcare®

Let's do this.

Thank you for being a member.

We're here to help make each step of your health care experience easier. Take a look at this guide to help you better understand your benefits, find care options, manage costs and get more out of your health plan.

What's inside:

- Getting started.
- Finding the care you need.



Call toll-free.

If you don't have computer access, need language assistance or still have questions after reading this, please call the toll-free member phone number on your health plan ID card.



Connect with us.

-  [Facebook.com/UnitedHealthcare](https://www.facebook.com/UnitedHealthcare)
-  [Twitter.com/UHC](https://twitter.com/UHC)
-  [Instagram.com/UnitedHealthcare](https://www.instagram.com/UnitedHealthcare)
-  [YouTube.com/UnitedHealthcare](https://www.youtube.com/UnitedHealthcare)



Activate your myuhc.com account.

When it comes to managing your health plan, myuhc.com[®] lets you see what's covered, manage costs and so much more. To help everyone get the most from their plan, it's important that each member age 18 and over create their own account. Use myuhc.com to:

- Find and estimate the cost of care.
- See what's covered.
- View claim details.
- Check your plan balances.
- Find network doctors.

Set up your account today.

- Go to myuhc.com > **Register Now**.
- Have your ID card handy and follow the step-by-step instructions.



Download the UnitedHealthcare app.

The **UnitedHealthcare**[®] app puts your health plan at your fingertips. Download it to:

- Find nearby care options in your network.
- See your claim details and view progress toward your deductible.
- View and share your health plan ID card with your doctor's office.
- Video chat with a doctor 24/7.



Simple ways to save.

Stay in the network.

The doctors and facilities in the network may have agreed to provide services at a discount—so staying in network makes sense, especially when visiting an out-of-network provider could end up costing you a lot more for care. Sign in to myuhc.com > **Find Care & Costs** or use the UnitedHealthcare app to locate:

- Labs
- Hospitals
- Mental health professionals
- Network doctors

Shop around.

With such a wide variety of services, from minor procedures to major surgeries, it's a good idea to check approximate pricing first. Visit myuhc.com > **Find Care & Costs** to estimate your costs. Members who comparison shop may save up to 36%* for care near them.

*UnitedHealthcare Internal Claims Analysis, 2015.



Get connected to care.

Pick a network PCP.

A PCP is a primary care provider, sometimes called a primary care physician or doctor. A PCP can be a family practitioner, internist, pediatrician or general medicine physician.* Although your plan may not require you to choose a PCP,** it's a good idea to have one. Your PCP generally:

- Knows your history.
- Builds an in-depth knowledge of your health over time.
- May guide you on the best path of care.
- Can advise you when to see a specialist and provide electronic referrals.

Find a network provider.

Sign in to myuhc.com > **Find Care & Costs** to find a network PCP, clinic, hospital or lab based on location, specialty, reputation, estimated cost of services, availability, hours of operation and more. You can even see patient ratings and compare cost estimates before you choose a provider. If you would like more information about a provider's qualifications, call the toll-free member phone number on your ID card.

Make more informed choices.

The **UnitedHealth Premium® program** uses national, evidence-based, standardized measures to evaluate physicians in various specialties to help you locate quality providers. Find UnitedHealth Premium Care Physicians by going to myuhc.com > **Find Care & Costs** and look for blue hearts. ♥♥

Keep up on preventive care.

Preventive care—such as routine wellness exams and certain recommended screenings and immunizations—is covered by most of our plans at no additional cost when you see network providers. A preventive care visit may be a good time to help establish your relationship and create a connection for future medical services. Learn more at uhc.com/preventivecare.



It's good
to know.



And good
to save.

*Laws in some states allow you to choose a specialist, like an OB/GYN, as your PCP.

** Depending on your health plan, selection of a PCP may be required.



Know what to do if you need:

Hospital care

Talk to your PCP first to determine which hospital in your network can meet your medical or surgical needs. You or the admitting physician may be required to notify us before you're admitted.

Referrals

If your ID card states "Referrals Required," you'll need an electronic referral from your PCP before seeking services from another network provider. Without it, your care may not be covered and you may end up paying more. To learn what services require referrals, or to confirm a referral has been made, sign in at myuhc.com > **Coverage & Benefits**.

Prior authorization

Your plan may also require prior authorization, sometimes called preauthorization, before you receive certain services. This means that you or your network provider may need to get approval from your plan before the services are covered. Call the toll-free member phone number on your ID card or sign in at myuhc.com > **Coverage & Benefits** to check if prior authorization is needed.



Here's how a typical health plan works.

Let's take a look at an example of how a typical plan works when you receive care from a network provider. Your plan may be different than this example, so to find your specific details go to myuhc.com > **Coverage & Benefits**.

		For example:
At the start of your plan year...	You're responsible for paying 100% of your covered health services until you reach your deductible , which is the amount you pay before your health plan pays a portion.	You pay 100%
Along the way...	You may also be required to pay a fixed amount—or copay —each time you see a provider.	You pay 100% of the copay
Once you reach your deductible...	Your health plan starts to share a percentage of the costs for covered health care services with you—this is your coinsurance .*	You pay 20%* Your plan pays 80%*
When you reach your out-of-pocket limit...	Your plan covers the costs (the allowed amount) for covered health services at 100%. Your out-of-pocket limit is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.	Your plan pays 100%

*Your coinsurance may vary by service. This example is for illustrative purposes only. Please visit myuhc.com > Coverage & Benefits for your coverage details.



Get to know your care options and costs.

How much you pay for care can depend on where you get it—and a great place to start is with your PCP. For serious or life-threatening conditions, call 911 or go to an emergency room.

Care Options



PCP

Care from the doctor who knows you best.



Virtual Visits

See a doctor whenever, wherever.



Convenience Care

Basic conditions that aren't life-threatening.



Urgent Care

Serious conditions that aren't life-threatening.



Emergency Room

Life- and limb-threatening emergencies.

Average Cost*	Varies by plan type	Less than \$50**	\$90	\$180	\$2,100
Hours	Varies by location	24/7	Varies by location	Varies by location — may be open nights/weekends	24/7
How to Connect	Contact your PCP	myuhc.com/ virtualvisits	myuhc.com	myuhc.com	myuhc.com

✓ indicates the suggested place for care when it comes to the following common conditions:

Broken bone				✓	✓
Chest pain					✓
Cough	✓	✓	✓		
Fever	✓	✓	✓		
Muscle strain	✓		✓		
Pinkeye	✓	✓	✓		
Shortness of breath					✓
Sinus problems	✓	✓	✓		
Sore throat	✓	✓	✓		
Sprain	✓		✓	✓	
Urinary tract infection	✓	✓	✓		

Did you know?

Emergency rooms are likely the most expensive place to get care. When you need to be seen, consider the chart above to help you find care. If you're still unsure about what's best for your situation, sign in to myuhc.com > **Find Care & Costs** to locate a network provider or call the member phone number on your ID card for support. If you have a question about what's covered by your plan, visit myuhc.com > **Coverage & Benefits** for answers.

*Source: 2018 Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated \$1,900.00 difference between the average emergency room visit and the average urgent care visit.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

**The Designated Virtual Visit Provider's reduced rate for a Virtual Visit is subject to change at any time. Virtual Visits may not be available to all members. Check your health plan to determine if these services are available.

Check your official health plan documents to see what services and providers are covered by your plan.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Mail: UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Online: UHC_Civil_Rights@uhc.com

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 member phone number listed on your ID card.

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, 1-800-537-7697 (TDD)

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

We provide free services to help you communicate with us such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID 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 русским (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تويوغللا قذعاسجلا تامدخ ناف، ةيبرعلا شحتت تنك اذا: ةدينت
للع جردملا يناعملا فتاهلا مقرب لاصتالا يجرى لكل ةحاتم ةيناعملا
كئب تصاخلا فيرعتلا قاطب

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.

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.

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.

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

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 shqódi ninaaltsoos nítł'izí bee nééhozinígíí bine'déç' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíłnih.



Visit www.uhc.com/legal/required-state-notice to view important state required notices.

Member phone number services should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the member phone number services are for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Your health information is kept confidential in accordance with the law. Member phone number services are not an insurance program and may be discontinued at any time.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. UnitedHealthcare also covers other routine services, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Evaluation of New Technologies: UnitedHealthcare's Medical Technology Assessment Committee reviews clinical evidence that impacts the determination of whether new technology and health services will be covered. The Medical Technology Assessment Committee is composed of Medical Directors with diverse specialties and subspecialties from throughout UnitedHealthcare and its affiliated companies, guest subject matter experts when required, and staff from various relevant areas within UnitedHealthcare. The Committee meets monthly to review published clinical evidence, information from government regulatory agencies and nationally accepted clinical position statements for new and existing medical technologies and treatments, to assist UnitedHealthcare in making informed coverage decisions.

For informational purposes only. Nurse, coach, and EAP services should not be used for emergency or urgent care situations. In an emergency, call 911 or go to the nearest emergency room. The nurse or coach service can't diagnose problems or recommend specific treatment. The information provided by the nurse, coach or EAP services are not a substitute for your doctor's care.

The UnitedHealth Premium[®] designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com. You should always visit myuhc.com for the most current information. **Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. You should also discuss designations with a physician before choosing him or her. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician.** Please visit myuhc.com for detailed program information and methodologies.

The information in this guide is a general description of your coverage. It is not a contract and does not replace the official benefit coverage documents which may include a Summary of Benefits and Coverage and Certificate of Coverage/Summary Plan Description. If descriptions, percentages, and dollar amounts in this guide differ from what is in the official benefit coverage documents, the official benefits coverage documents prevail.

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The UnitedHealthcare[®] app is available for download for iPhone[®] or Android[®].

Android is a registered trademark of Google LLC.

Google Play and the Google Play logo are registered trademarks of Google Inc.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Cost and Care section. Refer to your health plan coverage documents for information regarding your specific benefits.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.



**Preventive care
guidelines for
children and adults.**

Focusing on regular preventive care can help you—and your family—stay healthier.

Preventive care can help you avoid potentially serious health conditions and/or obtain early diagnosis and treatment. Generally, the sooner your doctor can identify and treat a medical condition, the better the outcome.

Under the Affordable Care Act (ACA),* most health plans provide coverage for certain preventive health care services covered at 100%, without any cost to you. Just obtain your preventive care from a health plan network provider. Diagnostic (non-preventive) services are also covered, but you may have to pay a copayment, coinsurance or deductible. Check your plan documents to make sure.

Preventive care guidelines for children.**

Recommended preventive care services for children will vary based on age and may include some of the following:

- Age-appropriate well-child examination.
- Anemia screening.
- Cholesterol screening for children 24 months and older.
- Metabolic screening panel for newborns.
- Vaccines and immunizations. For more information, visit [cdc.gov/vaccines](https://www.cdc.gov/vaccines).
- Vision screening by a primary care physician.
- Fluoride application by primary care physician for children younger than 6-years old.
- Hearing screening by primary care physician.
- Autism and Developmental screening for children under age 3.
- Counseling by a primary care physician on the harmful effects of smoking and illicit use of drugs (children and adolescents beginning at 11 years old).
- Counseling for children on promoting improvements in weight.
- Screening certain children at high risk for sexually transmitted diseases, lead, depression and tuberculosis.
- Behavioral Counseling to prevent skin cancer at each wellness examination.

Not all children require all of the services identified above.*** Your doctor should give you information about your child's growth, development and general health, and answer any questions you may have.



Help protect and maintain your child's health with regular preventive care visits with a network doctor.

* 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 and other health factors. UnitedHealthcare also covers other routine services that may require a copay, coinsurance or deductible. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card.

** These guidelines are based, in part, on the requirements of the Patient Protection and Affordable Care Act, and recommendations of the U.S. Preventive Services Task Force (USPSTF), the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services, and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Individuals with symptoms or at high risk for disease may need additional services or more frequent interventions that may not be covered as a preventive benefit. These guidelines do not necessarily reflect the vaccines, screenings or tests that will be covered by your benefit plan. These clinical guidelines are provided for informational purposes only, and do not constitute medical advice. Preventive care benefits may not apply to certain services listed above. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card.

*** Development, psychosocial and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Discuss with your doctor how these guidelines may be right for your child, and always consult your doctor before making any decisions about medical care. These clinical guidelines are provided for informational purposes only, and do not constitute medical advice. Preventive care benefits may not apply to certain services listed above. Always refer to your plan documents for your specific coverage.

Preventive care screening guidelines and counseling services for adults.*

A preventive health visit can help you see how healthy you are now and help identify any health issues before they become more serious. You and your doctor can then work together to choose the care that may be right for you. Recommended preventive care services may include the following:

- **Wellness Examinations.**
- **Well-Woman Visits** — including routine prenatal visits.
- **Abdominal Aortic Aneurysm Screening**—for age 65–75 years who have ever smoked.
- **Alcohol Screening and Brief Counseling**—screening during wellness examinations. Brief counseling interventions for certain patients.
- **Bacteriuria Screening**—during pregnancy.
- **Blood Pressure Screening**—at each wellness examination. Certain patients may also require ambulatory blood pressure measurements outside of a clinical setting. Check with your doctor.
- **Breastfeeding, Counseling, Support and Supplies**—during pregnancy and after birth. Includes personal use electric breast pump.
- **Cervical Cancer Screening (Pap Smear)**—women age 21–65 years old.
- **Chemoprevention of Breast Cancer, Counseling**—for women at high risk of breast cancer, but low risk for adverse effects.
- **Chlamydia and Gonorrhea Infection Screening**—for sexually active women age 24 and younger, and older women at increased risk.
- **Cholesterol Screening**—for age 40–75 years.
- **Colorectal Cancer Screening**—for age 50–75 years. Ask your physician about screening methods and intervals for screening.
- **Contraceptive Methods**—FDA-approved methods of contraception for women, including patient education and counseling.
- **Depression Screening**—for all adults, in a primary care setting.
- **Diabetes Screening**—for age 40–70 who are overweight or obese or for those of any age that have a history of gestational diabetes.
- **Falls Prevention Counseling**—during wellness examination, for community-dwelling older adults.
- **Genetic Counseling and Evaluation for BRCA Testing, and BRCA Lab Testing**—lab testing requires prior authorization.
- **Gestational Diabetes Mellitus Screening**—during pregnancy
- **Healthy Diet Behavioral Counseling**—for persons with cardiovascular disease risk factors, in a primary care setting.
- **Hepatitis B Virus Infection Screening**—during pregnancy and for persons at high risk.
- **Hepatitis C Virus Infection Screening**—one-time screening for adults born between 1945–1965, or, persons at high risk.
- **Human Immunodeficiency Virus (HIV) Screening**—for all adults.
- **Human Papillomavirus DNA Testing**—for women aged 30 and up.
- **Latent Tuberculosis Infection Screening**—for persons at increased risk.
- **Lung Cancer Screening with Low-Dose CT Scan**—for age 55–80 years with at least a 30 pack-year history (with prior authorization).
- **Mammography Screening.**
- **Obesity Screening and Counseling**—at each wellness examination.
- **Osteoporosis Screening**—women age 65 and older, and younger women at increased risk.
- **Rh Incompatibility Screening**—during pregnancy.
- **Sexually Transmitted Infections, Behavioral Counseling to Prevent**—behavioral counseling for adults who are sexually active or otherwise at increased risk, in a primary care setting.
- **Skin Cancer, Behavioral Counseling to Prevent**—at each wellness examination, for young adults up to age 24 years.
- **Syphilis Screening**—for adults at increased risk.
- **Tobacco Cessation, Screening, Behavioral Counseling**—screening, and behavioral counseling for adults who smoke, in a primary care setting (refer to pharmacy vendor for pharmacotherapy for tobacco cessation).
- **Vaccines and Immunizations**—FDA approved and have explicit ACIP recommendations for routine use. For more information, visit [cdc.gov/vaccines](https://www.cdc.gov/vaccines).

* These guidelines are based, in part, on the requirements of the Patient Protection and Affordable Care Act, and recommendations of the U.S. Preventive Services Task Force (USPSTF), the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services, and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Individuals with symptoms or at high risk for disease may need additional services or more frequent interventions that may not be covered as a preventive benefit. These guidelines do not necessarily reflect the vaccines, screenings or tests that will be covered by your benefit plan. These clinical guidelines are provided for informational purposes only, and do not constitute medical advice. Preventive care benefits may not apply to certain services listed above. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card



Questions?

For more information about preventive guidelines, visit uhc.com/preventivecare.



Source: Centers for Disease Control and Prevention, Recommended immunization schedules for children and adolescents aged 18 years or younger - United States, 2019, at: <https://www.cdc.gov/vaccines/schedules/index.html>.

Additional information about the vaccines in this schedule, extent of available data, including a full list of footnotes and contraindications for vaccination is also available at [cdc.gov/vaccines](https://www.cdc.gov/vaccines) or from the CDC-INFO Contact Center at 1-800-CDC-INFO (1-800-232-4636) in English and Spanish, 8 a.m.–8 p.m. Eastern Time, Monday–Friday, excluding holidays.

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Benefit Summary
ASO Choice Plus HSA- UnitedHealthcare Choice Plus Consumer Directed Health Plan
 Brown University Medical Plan

United HealthCare Services, Inc. and Brown University want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com**[®] - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD 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.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – Combined Medical and Pharmacy		
Single Coverage Deductible	\$1,500 per year	\$1,500 per year
Family Coverage Deductible	\$3,000 per year	\$3,000 per year
<ul style="list-style-type: none"> • No one in the family is eligible for benefits until the family coverage deductible is met. 		
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Single Coverage Out-of-Pocket Maximum	\$2,750 per year	\$2,750 per year
Family Coverage Out-of-Pocket Maximum	\$5,500 per year	\$5,500 per year
<ul style="list-style-type: none"> • The Out-of-Pocket Maximum includes the Annual Deductible. • If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. 		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	90% after Deductible has been met	70% after Deductible has been met
Lifetime Maximum Benefit		
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	No Lifetime Maximum Benefit	No Lifetime Maximum Benefit
Prescription Drug Benefits		
<ul style="list-style-type: none"> • Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met. 		
Information of Pre-service Notification		
*Pre-service Notification is required for certain services.		
**Pre-service Notification is required for Equipment in excess of \$1,000.		
Information on Benefit Limits		
<ul style="list-style-type: none"> • The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. 		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Dental Services – Accident Only		
Benefits are limited to \$3,000 maximum per year and \$900 maximum per tooth	* 90% after Deductible has been met	* 70% after Network Deductible has been met
Durable Medical Equipment (DME) ¹		
Benefits are limited as follows: limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	90% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	90% after Deductible has been met	* 90% after Network Deductible has been met
Hearing Aids		
Benefits are limited as follows: limited to a single purchase (including repair/replacement) per hearing impaired ear every two years.	90% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met	* 70% after Deductible has been met

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BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Hospice Care		
	90% after Deductible has been met	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	90% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90% after Deductible has been met	70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	90% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* 70% after Deductible has been met
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* 70% after Deductible has been met
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	90% after Deductible has been met	70% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	90% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	90% after Deductible has been met	70% after Deductible has been met
Specialist Physician Office Visit	90% after Deductible has been met	70% after Deductible has been met
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
		<i>Pre-service Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	70% after Deductible has been met
Specialist Physician Office Visit	100% Deductible does not apply.	70% after deductible has been met
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	70% after deductible has been met
Prosthetic Devices¹		
Benefits are limited as follows: and are limited to a single purchase of each type of prosthetic device every three years.	90% after Deductible has been met	70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Pre-service Notification is required.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 30 visits of physical therapy 30 visits of occupational therapy 20 visits of manipulative treatment 30 visits of speech therapy 30 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy Combined with occupational therapy-cognitive rehabilitation therapy Benefits for Habilitative Services are subject to the limits as stated in the benefits section	90% after Deductible has been met	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	90% after Deductible has been met	70% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 100 days per year	90% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* 70% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Surgery – Outpatient	90% after Deductible has been met	70% after Deductible has been met
Transplantation Services	* 90% after Deductible has been met	* 70% after Deductible has been met
Urgent Care Center Services	90% after Deductible has been met	70% after Deductible has been met
Virtual Visits	90% after Deductible has been met	Non-Network Benefits are not available
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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.	90% after Deductible has been met	Non-Network Benefits are not available
Vision Examinations	90% after Deductible has been met	Non-Network Benefits are not available
Benefits are limited as follows: 1 exam every calendar year	90% after Deductible has been met	Non-Network Benefits are not available

* This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.

MEDICAL EXCLUSIONS		
It is recommended that you review your SPD 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		
Acupuncture; aromatherapy; hypnosis; massage therapy; rolfing (holistic tissue massage); art, music, dance, 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 Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.		
Dental		
Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). 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 Plan as described in the SPD. 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 dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. 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 the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.		
Devices, Appliances and Prosthetics		
Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.		
Drugs		
The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs 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 characteristics (as determined by United HealthCare Services, Inc.), 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 consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.		
Experimental or Investigational or Unproven Services		
Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your 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 the SPD.		
Foot Care		
Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. 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 for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.		
Medical Supplies and Equipment		
Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to: <ul style="list-style-type: none"> • Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD. • Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD. • Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD. Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.		
Mental Health / Substance Use Disorder		
Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental retardation as a primary diagnosis defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozine, or their equivalents for drug addiction. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.		
Nutrition		
Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.		
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 and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.		
Physical Appearance		
Cosmetic Procedures. See the definition in the SPD. 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; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; 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 intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs		

regardless of the reason for the hair loss, except for temporary loss of hair resulting from treatment of a malignancy.

MEDICAL EXCLUSIONS

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, 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 Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. 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 disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking 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. Chelation therapy, except to treat heavy metal poisoning.

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 residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. 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. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

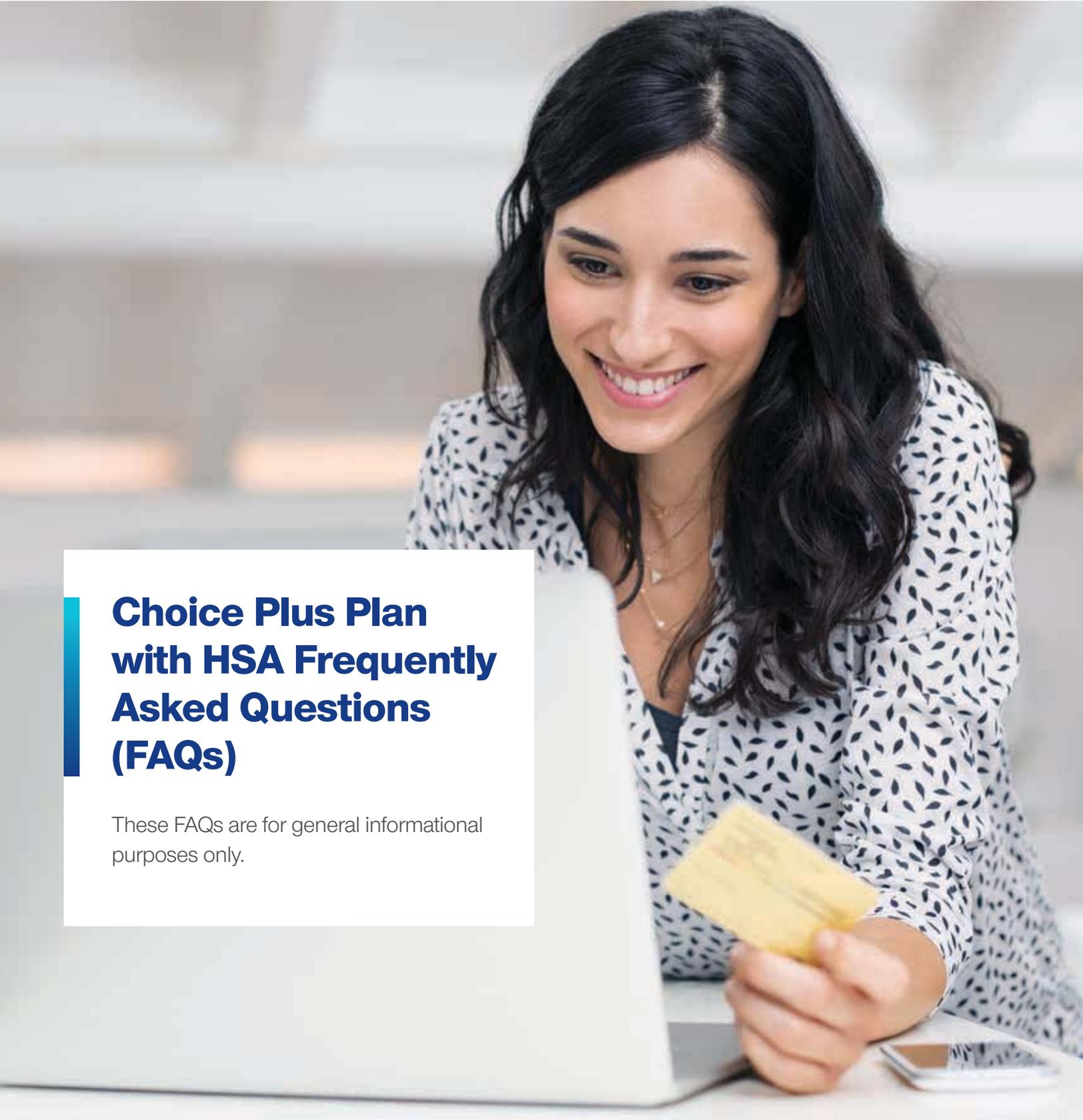
Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health 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 to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactivity disorder; TBI; or dyslexia.



Choice Plus Plan with HSA Frequently Asked Questions (FAQs)

These FAQs are for general informational purposes only.

Terms to understand

What is a deductible?

A deductible is the amount you have to pay for covered health care services before your health plan starts to pay. You don't need to pay a deductible for covered preventive care services if they are received in the network.

Do I really have to pay the full cost of covered health care services before I meet the deductible?

Yes. You will pay for all covered health care services until you reach your deductible. You can use a health savings account (HSA) to help pay or you can save it to use later. Using network providers will help lower your cost.

What is coinsurance?

After you've paid your deductible, you only pay a percentage of the cost for each covered service, called coinsurance (e.g., your plan pays 80% and you pay 20%).

What is an out-of-pocket limit?

The out-of-pocket limit is the most you have to pay for covered services in a plan year. If your deductible and coinsurance payments reach the out-of-pocket limit, your plan will pay 100% of covered services for the rest of the year.

Specifics of the plan

Why does the plan have a high deductible?

To open and put money into an HSA, you must have a high deductible health plan. This is one of the rules set by the Internal Revenue Service (IRS). This type of plan is meant to help you take a more active role in your health care buying decisions.

How is this plan different from a copayment plan?

Most traditional copayment plans focus on managing your health benefits. This plan focuses on managing your health by encouraging you to:

- Take a more active role in your health care buying decisions.
- Make healthier choices and seek quality care.
- Open an HSA, which you can't get with a traditional plan.

Can I see any doctor I want? Why am I asked to use network providers?

Yes, you can see any doctor you want. You are encouraged to use health care providers in the network because they've agreed to charge lower prices. For example, when you use a network doctor, you'll usually pay less compared to one who is not in the network.

Do I need to choose a primary care provider and get a referral to see a specialist?

No. You have the freedom to use any doctor or hospital without being required to choose a primary care physician (PCP) or get referrals.

Are emergency room and urgent care services covered?

Yes, emergency room and urgent care services are covered.

Can I cover my children and other dependents under this plan?

Yes, adult children are eligible for coverage under the plan up to age 26. Dependents younger than 19 cannot be denied coverage because of a pre-existing medical condition.



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- Access your health plan ID card.
- Check claim updates.
- Find physicians and facilities.
- Estimate costs.

Opening an HSA

What is a health savings account or HSA?

An HSA is a bank account that lets people put money aside, tax-free, to save and pay for qualified health care expenses. It's a real bank account, but you don't pay federal income tax on the money you deposit into it or the money you use for qualified medical expenses. You can even build your savings into a nest egg for retirement.

What are the requirements for opening an HSA?

To deposit money into an HSA, you must be enrolled in an HSA-eligible health plan.

You are eligible if:

- You are covered under an eligible high deductible health plan (HDHP).
- You are covered by no other health coverage, unless it is permissible coverage.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

Some other restrictions apply. Please talk to a tax, benefits or financial advisor if you have more questions.

Can I open an HSA if I have a health care flexible spending account (FSA)?

No. All of the money in your health care FSA must be spent before you can open an HSA.

Is it OK if I wait to open my HSA?

It's important to open and make a deposit into your HSA as soon as the plan year starts. That way, you will be prepared if you need to pay or reimburse yourself for any services early in the year. If you have any expenses before you open your HSA, you can't use your HSA to reimburse yourself later.

If my spouse is on Medicare, can I open and contribute to an HSA?

Yes. If a spouse will be or is already covered by Medicare, you can sign up for this plan and open and contribute to an HSA. If you file taxes jointly with your spouse, you can use your HSA to help pay for your spouse's qualified expenses, such as Medicare premiums.

What is a qualified medical expense?

According to the IRS, a qualified medical expense is a health care service or item that would qualify for a tax deduction. This means you can use an HSA to pay for these expenses and without paying taxes on them. Go to [IRS.gov](https://www.irs.gov) to learn more about which expenses can be paid with an HSA.

What expenses don't qualify for tax benefits?

Examples of expenses that do not qualify include cosmetic surgery, health club memberships, teeth whitening and over-the-counter medicines purchased without a prescription. If you use an HSA to pay for an expense that is not qualified, you will have to pay taxes on the expense and may also have to pay a 20% penalty.

Can I use any bank?

Yes. You can open your HSA with any bank of your choice. Optum Bank® is your employer's preferred health care bank and a national leader in HSA banking.

Using an HSA

Is there a limit on how much I can put into my HSA each year?

Yes. The IRS limits how much you (and others) can put into an HSA each year.

The 2020 limits are:

- \$3,550 for individual coverage.
- \$7,100 for family coverage.

If you are 55 or older, you can deposit an extra \$1,000 during the year. This is called a catch-up contribution. Any contributions above these limits are subject to income taxes and a penalty.

Do I have to pay federal taxes on the money I deposit into an HSA?

When you deposit money into an HSA, you won't have to pay federal income tax on:

- Deposits you or others make into your HSA.
- Money you spend from your HSA on qualified expenses.
- Interest earned from the HSA.

Can other people put money into my HSA?

Yes, anyone can contribute to your HSA.

What happens if I leave my current employer, change health plans or retire?

The money in your HSA is yours to keep. If you leave your company, change health plans or retire, you take your HSA with you. If you switch to a health plan that makes you ineligible to continue depositing money in an HSA, you may continue to use the money in your account for qualified medical expenses, but you can no longer make deposits.

Contributing to an HSA

If my spouse has his or her own health plan with an HSA, can I also contribute to it?

Yes, but the IRS says the two of you together can only contribute up to the family limit. Both of you can contribute to just one of your HSAs, or you can contribute to both HSAs as long as the total amount doesn't go above the annual family limit.

I want my HSA dollars to go as far as possible. How can I find out how much a treatment or procedure is going to cost?

After you enroll, you will have tools on myuhc.com[®] that can help you estimate the cost of treatments and other procedures based on your health plan, a specific doctor or hospital and your ZIP code.

How do I pay with an HSA?

If you receive a bill from your doctor or if you are paying for a prescription, you can pay from your HSA using your HSA debit card or checks provided by your bank.

If I paid a health care bill with my credit card, can I pay myself back from my HSA?

Yes, as long as the service is a qualified expense. You can take money out of your HSA to pay yourself back with no penalty.

Can I use the HSA for my spouse or dependents if they're not covered under my plan?

You can use the HSA to pay for qualified expenses of any family member if they are claimed as a spouse or dependent on your taxes. If a tax dependent is not covered under your plan, and you use your HSA to pay for their expenses, those expenses will not go toward your deductible.

If I am covering an adult child, can I use my HSA to help pay for his or her qualified medical expenses?

Your child must be a tax dependent to use your HSA. If your child is not a tax dependent, but is covered by your plan, he or she may be able to open his or her own HSA.

If I'm 65 or older and decide to retire, what happens to my HSA?

After you turn 65 or start receiving Medicare benefits, you may withdraw money from your HSA for medical and non-medical purposes without penalty. When your Medicare coverage starts, you can use your HSA to pay your Medicare premiums, deductibles and copayments.

If I cover my domestic partner under my plan, can I use my HSA for my partner's medical expenses?

If your domestic partner meets the IRS qualifications of a tax dependent, you can use your HSA to help pay his or her qualified expenses. If your partner is not a tax dependent, you can still cover your partner under your plan. However, your partner would need to open and fund his or her own HSA to pay for the expenses.

Can I have an HSA and a health care flexible spending account (FSA)?

No. If you are enrolled in a health care FSA, the IRS will not allow you to open an HSA. But the law does permit you to enroll in a limited-purpose FSA if it is offered to you. A limited-purpose FSA can only be used to pay for eligible dental and vision expenses.

I still have money in my health care FSA. Can I open an HSA?

No. All of the money in your health care FSA must be spent before you can open an HSA.



Contact your UnitedHealthcare representative for additional information.



The UnitedHealthcare plan with Health Savings Account (HSA) is a high deductible health plan (HDHP) that is designed to comply with IRS requirements so eligible enrollees may open a Health Savings Account (HSA) with a bank of their choice or through Optum Bank, Member of FDIC. The HSA refers only and specifically to the Health Savings Account that is provided in conjunction with a particular bank, such as Optum Bank, and not to the associated HDHP. All UnitedHealthcare members can access a cost estimator online tool.

Depending on your specific benefit plan and the ZIP code that is entered, either the myHealthcare Cost Estimator, or the Treatment Cost Estimator will be available. A mobile version of myHealthcare Cost Estimator is available, and additional ZIP codes and procedures will be added soon. This tool is not intended to be a guarantee of your costs or benefits. Your actual costs and/or benefits may vary. When accessing the tool, please refer to the Terms and Conditions of Use and Why Your Costs May Vary sections for further information regarding cost estimates. Refer to your health plan coverage document for information regarding your specific benefits.

This communication is not intended as legal or tax advice. Please contact a competent legal or tax professional for personal advice on eligibility, tax treatment and restrictions. Federal and state laws and regulations are subject to change.

Information for individuals residing in the state of Louisiana or who have policies issued in Louisiana: Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of these fees for those non-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles and non-covered services. Specific information about network and non-network facility-based physicians can be found at myuhc.com or by calling the toll-free Customer Care telephone number on the back of your health plan ID card.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

[Facebook.com/UnitedHealthcare](https://www.facebook.com/UnitedHealthcare) [Twitter.com/UHC](https://twitter.com/UHC) [Instagram.com/UnitedHealthcare](https://www.instagram.com/UnitedHealthcare) [YouTube.com/UnitedHealthcare](https://www.youtube.com/UnitedHealthcare)

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**Benefit Summary
ASO Choice Plus**

Brown University Medical Plan

This document is provided as a sample and does not reflect actual benefits. A customized Benefit Summary or Summary Plan Description (SPD) will be created during implementation of the business.

United HealthCare Services, Inc. and Brown University want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com**® - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD 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.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	No Annual Deductible	\$200 per year
Family Deductible	No Annual Deductible	\$600 per year
<ul style="list-style-type: none"> • Member Copayments do not accumulate towards the Deductible. 		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$2,750 per year	\$2,750 per year
Family Out-of-Pocket Maximum	\$5,500 per year	\$5,500 per year
<ul style="list-style-type: none"> • The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. 		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	100% after Deductible has been met.	80% after Deductible has been met.
Prescription Drug Benefits		
<ul style="list-style-type: none"> • Prescription drug benefits are shown under separate cover. 		
Information on Benefit Limits		
<ul style="list-style-type: none"> • The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. • In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services. 		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	Emergency: 100% after you pay a \$50 Copayment per visit Non-Emergency: 100% after you pay a \$50 Copayment per visit <i>Pre Service Notification is required for Non-Emergency Ambulance.</i>	Emergency: 100% after you pay a \$50 Copayment per visit Non-Emergency: 100% after you pay a \$50 Copayment per visit <i>Pre Service Notification is required for Non-Emergency Ambulance.</i>
Dental Services – Accident Only		
	80% Deductible does not Apply	80% Deductible does not apply
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	80%	80% after Deductible has been met. <i>Pre Service Notification is required for Durable Medical Equipment that costs more than \$1,000.</i>

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BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Emergency Health Services - Outpatient		
	100% after you pay a \$75 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	100% after you pay a \$75 Copayment per visit.
Gender Dysphoria		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits.	
		<i>Pre Service Notification is required for certain services.</i>
Hearing Aids		
Benefits are limited as follows: A single purchase (including repair/replacement) per hearing impaired ear every two years.	100%	80% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 6 home or office Physician's visit per month, 3 nursing visits per week, and 20 hours of home health aide visits per week	80%	80% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i>
Hospice Care		
Benefits are limited as follows: 180 days during the entire period of time a Covered Person is covered under the policy	100%.	80% after Deductible has been met. <i>Pre-service Notification is required for Inpatient Stay.</i>
Hospital – Inpatient Stay		
	100%	80% after Deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100%.	80% after Deductible has been met.
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	100%	80% after Deductible has been met.
Mental Health Services		
	100% per Inpatient Stay. 100% after you pay a \$10 Copayment per visit.	80% after Deductible has been met.

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Neurobiological Disorders - Autism Spectrum Disorders		
	100% per Inpatient Stay. 100% after you pay a \$10 Copayment per visit. Benefits for outpatient visits for medication management will be paid at 100%.	80% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i>
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	100%.	80% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	100%.	80% after Deductible has been met.
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	100% after you pay a \$10 Copayment per visit.	80% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a \$10 Copayment per visit.	80% after Deductible has been met.
> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.		
		<i>Pre-service Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100%.	80% after deductible has been met.
Specialist Physician Office Visit	100%	
Lab, X-Ray or other preventive tests	100% .	
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80%	80% after Deductible has been met. <i>Pre-service Notification is required for Prosthetic Devices that costs more than \$1,000.</i>
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		<i>Pre-service Notification is required for certain services.</i>

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 30 visits of physical therapy 30 visits of occupational therapy 20 visits of manipulative treatment 30 visits of speech therapy 30 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy	80%	80% after Deductible has been met.
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	100%.	80% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 100 days per year	100%	80% after Deductible has been met.
Substance Use Disorder Services		
	100% per Inpatient Stay. 100% after you pay a \$10 Copayment per visit. Benefits for outpatient visits for medication management will be paid at 100%	80% after Deductible has been met.
Surgery – Outpatient		
	100% after Deductible has been met.	80% after Deductible has been met.
Transplantation Services		
	100%	80% after Deductible has been met.
Urgent Care Center Services		
	100% after you pay a \$10 Copayment per visit.	80% after Deductible has been met.
> In addition to the Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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.	100%	Non-Network Benefits are not available.
Vision Examinations		
Benefits are limited as follows: 1 exam every 1 year	100% after you pay a \$10 Copayment per visit.	Non-Network Benefits are not available.

MEDICAL EXCLUSIONS		
It is recommended that you review your SPD 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		
Acupuncture; aromatherapy; hypnosis; massage therapy; rolfing (holistic tissue massage); art, music, dance, 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 Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.		
Dental		
Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). 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 Plan as described in the SPD. 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 dental caries 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: extractions (including wisdom teeth), restoration and replacement of teeth, medical or surgical treatments of dental conditions, services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. 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 the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.		

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Devices, Appliances and Prosthetics		
Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.		
Drugs		
The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs 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 characteristics (as determined by United HealthCare Services, Inc.), 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 consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.		
Experimental or Investigational or Unproven Services		
Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your 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 the SPD.		
Foot Care		
Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. 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 for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges, shoe orthotics, shoe inserts and 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.		
Medical Supplies and Equipment		
Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to: <ul style="list-style-type: none"> • Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD. • Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD. • Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD. Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.		
Mental Health, Neurobiological/Autism Spectrum, and Substance-Related and Addictive Disorders		
<i>If Intensive Behavioral Therapies are covered, remove bracketed language. If Intensive Behavioral Therapies is not covered remove red brackets. (Delete blue instructional text).</i> Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the <i>Individuals with Disabilities Education Act</i> . Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the <i>Individuals with Disabilities Education Act</i> . Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents for drug addiction. [Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders.] Transitional Living services.		
Nutrition		
Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.		

Personal Care, Comfort or Convenience

Option 1: Use this language for Prior Authorization. Delete blue instructional text and other language in option#2:

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 and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot and cold compresses; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Option 2: Use this language for Pre-service Notification. Delete blue instructional text and other language in option#1:

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 and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot and cold compresses; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemo-surgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; 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 intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss, except for temporary loss of hair resulting from treatment of a malignancy.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. 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 Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. 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. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniocervical therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking 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. Chelation therapy, except to treat heavy metal poisoning.

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 residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. 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. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide), and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy. Routine vision examinations, including refractive examinations to determine the need for vision correction.

All Other Exclusions

Option 1: Use this language for Prior Authorization. Delete blue instructional text and other language in option#2:

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health 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 to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactive disorder; TBI; or dyslexia.

Option 2: Use this language for Pre-service Notification. Delete blue instructional text and other language in option#1:

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health 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 to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactive disorder; TBI; or dyslexia.

United HealthCare Services, Inc. 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 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 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 other 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

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

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè 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 निःशुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री 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**khmer (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 yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i. T'áá shqódí ninaaltsoos nitl'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodiilnih.

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



See a doctor whenever, wherever. Virtual Visits

When you're sick and need care quick, a Virtual Visit is a convenient way to start feeling better faster.

With a Virtual Visit, you can see and talk to a doctor via mobile device or computer - 24/7, no appointment needed. The doctor can give you a diagnosis and prescription*, if needed. And with a UnitedHealthcare plan, your cost is \$50 or less.

To get started with a Virtual Visit, go to uhc.com/virtualvisits.

Get care in 20 minutes or less.

Use a Virtual Visit for these minor medical needs:

- Bladder infection/ Urinary tract infection
- Rash
- Bronchitis
- Sinus problems
- Cold/ flu
- Sore throat
- Fever
- Stomachache
- Pinkeye

Prepare for your Virtual Visit.

Have these three items ready to register and complete your Virtual Visit:

- Health plan ID card
- Credit card
- Pharmacy location

* Prescription services may not be available in all states.

** Based on analysis of 2016 UnitedHealthcare ER claim volumes, where ER visits are low-acuity and could be treated in a Virtual Visit, PCP, or urgent/convenient care setting.

Virtual visits are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. The Designated Virtual Visit Provider's reduced rate for a virtual visit is subject to change at any time.

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Virtual Visits can save time and money.

An estimated 25 percent of ER visits could be treated with a Virtual Visit — which brings a potential \$1,700 cost down to \$50.**



Stressed? Anxious? With virtual therapy, getting help may now be easier than ever.



Reaching out may be hard—especially if you might not want anyone to know you're hurting. From the privacy of home and the convenience of your mobile device* or computer, you can receive caring support from a licensed behavioral health virtual therapist.

Virtual therapy offers confidential counseling and includes:

Private video sessions.

Get 1-on-1 support—in your home and at a time that's convenient for you.

Help with coping—for children, teens and adults.

Your licensed virtual therapist may provide a diagnosis, treatment and medication if needed.

Similar standard of care as in-person visits.

You can see the same therapist with each appointment and establish an ongoing relationship.

Virtual therapy is designed to help treat conditions like:

- ADD/ADHD
- Depression
- Addiction
- Mental health disorders
- Anxiety



A quicker way for the whole family to get care.

Virtual therapy may be a great way for children and teens to get an appointment.

To find a provider and schedule a visit:

- 1 Sign in or register on myuhc.com[®]. Then, go to **Find a Doctor > Behavioral Health Directory > People > Provider Type > Telemental Health Providers**.
- 2 Call the provider to set up an appointment.

Take steps to help lose weight and keep it off, at no additional cost.

Real Appeal® is an online weight loss program that provides personal coaching to help you and eligible family members lose weight and keep it off. On average, participants lose 10 pounds after attending just 4 online sessions.*



Get support to help reach your goals.

1-on-1 coaching.

Get help to stay on track to reach your goals with online, coach-led group sessions.

\$0 out-of-pocket.

Real Appeal is offered at no additional cost, as part of your health plan benefits.

Success kit.

Get scales, recipes, fitness equipment and more delivered to your door.

Sandy

60 lbs.
lost

“It has given me the tools to eat healthfully and taught me the right amount of exercise that will make a difference. With personal coaching and weekly education on living a healthy lifestyle, I lost 60 pounds, and I feel great.”



Learn more and start today at success.realappeal.com



*Real Appeal is a voluntary weight loss program that is offered to eligible participants over age 18 at no additional cost as part of their plan benefits. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program. Talk to your doctor before starting any weight loss program.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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