UnitedHealthcare®

# Benefit Summary

Heritage Plus Silver 3500
Tennessee - Heritage Plus
Primary Advantage - Plan BSKI

## What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It’s always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

## What are the benefits of the Heritage Plus Primary Advantage Plan?

**Get more protection with a national network and out-of-network coverage.**

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

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

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

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

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

**Are you a member?**

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

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

## Benefits At-A-Glance

**What you may pay for network care**

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

| Co-payment (Your cost for an office visit) | Individual Deductible (Your cost before the plan starts to pay) | Co-insurance (Your cost share after the deductible) |
|---|---|---|
| $45 | $3,500 | You have no co-insurance. |

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

UnitedHealthcare Insurance Company of the River Valley

## Your Costs

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

| | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Annual Deductible** | | |

**What is an annual deductible?**

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

> Your co-pays do not count towards meeting the deductible unless otherwise described within the specific covered health care service.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

| | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| Medical Deductible - Individual | $3,500 per year | $10,000 per year |
| Medical Deductible - Family | $7,000 per year | $20,000 per year |
| Dental - Pediatric Services Deductible - Individual | Included in your medical deductible. | Included in your medical deductible. |
| Dental - Pediatric Services Deductible - Family | Included in your medical deductible. | Included in your medical deductible. |

### Out-of-Pocket Limit

**What is an out-of-pocket limit?**

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

| | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| Out-of-Pocket Limit - Individual | $7,500 per year | $15,000 per year |
| Out-of-Pocket Limit - Family | $15,000 per year | $30,000 per year |

## Your Costs

**What is co-insurance?**

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

**What is a co-payment?**

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

**What is Prior Authorization?**

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

**Want more information?**

Find additional definitions in the glossary at justplainclear.com.

## Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Allergy Testing and Injections** | | |
| Allergy Testing: | $45 co-pay per visit for a primary care physician office visit. A deductible does not apply.<br>$90 co-pay per visit for a specialist office visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| Allergy Injections: | 20% co-insurance per injection, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| **Ambulance Services** | | |
| Emergency Ambulance: | 20% co-insurance, after the medical deductible has been met. | 20% co-insurance, after the network medical deductible has been met. |
| Non-Emergency Ambulance: | 20% co-insurance, after the medical deductible has been met.<br>Prior Authorization is required for Non-Emergency Ambulance. | 30% co-insurance, after the medical deductible has been met.<br>Prior Authorization is required for Non-Emergency Ambulance. |
| **Cellular and Gene Therapy** | | |
| For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider. | The amount you pay is based on where the covered health care service is provided.<br>Prior Authorization is required. | Out-of-Network Benefits are not available. |
| **Clinical Trials** | | |
| | The amount you pay is based on where the covered health care service is provided. | |
| | Prior Authorization is required. | Prior Authorization is required. |
| **Dental Anesthesia Services for Children** | | |
| | The amount you pay is based on where the covered health care service is provided. | |
| | Prior Authorization is required. | Prior Authorization is required. |
| **Dental - Pediatric Services (Benefits covered up to age 19)** | | |
| Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th). | | |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Dental - Pediatric Preventive Services** | | |
| **Dental Prophylaxis (Cleanings)** Limited to two times every 12 months. | You pay nothing. A deductible does not apply. | 20% co-insurance. A deductible does not apply. |
| **Fluoride Treatments** Limited to two times every 12 months. | You pay nothing. A deductible does not apply. | 20% co-insurance. A deductible does not apply. |
| **Sealants (Protective Coating)** Limited to once per first or second permanent molar every 36 months. | You pay nothing. A deductible does not apply. | 20% co-insurance. A deductible does not apply. |
| **Space Maintainers (Spacers)** | You pay nothing. A deductible does not apply. | 20% co-insurance. A deductible does not apply. |
| **Dental - Pediatric Diagnostic Services** | | |
| **Evaluations (Check-up Exams)** Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. | You pay nothing. A deductible does not apply. | 20% co-insurance. A deductible does not apply. |
| **Intraoral Radiographs (X-ray)** Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image. | You pay nothing. A deductible does not apply. | 20% co-insurance. A deductible does not apply. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Dental - Pediatric Basic Dental Services** | | |
| **Endodontics (Root Canal Therapy)** | 20% co-insurance, after the medical deductible has been met. | 40% co-insurance, after the medical deductible has been met. |
| **Adjunctive Services**<br>Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit.<br>General Anesthesia: Covered only when clinically Necessary.<br>Occlusal Guard: Limited to one guard every 12 months. | 20% co-insurance, after the medical deductible has been met. | 40% co-insurance, after the medical deductible has been met. |
| **Oral Surgery** | 20% co-insurance, after the medical deductible has been met. | 40% co-insurance, after the medical deductible has been met. |
| **Periodontics**<br>Periodontal Surgery: Limited to one every 36 months per surgical area.<br>Scaling and Root Planing: Limited to one time per quadrant every 24 months.<br>Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis. | 20% co-insurance, after the medical deductible has been met. | 40% co-insurance, after the medical deductible has been met. |
| **Minor Restorative Services (Amalgam or Anterior Composite)** | 20% co-insurance, after the medical deductible has been met. | 40% co-insurance, after the medical deductible has been met. |
| **Simple Extractions (Simple tooth removal)**<br>Limited to one time per tooth per lifetime. | 20% co-insurance, after the medical deductible has been met. | 40% co-insurance, after the medical deductible has been met. |
| **Dental - Pediatric Major Restorative Services** | | |
| **Crowns/Inlays/Onlays**<br>Limited to one time per tooth every 60 months. | 40% co-insurance, after the medical deductible has been met. | 50% co-insurance, after the medical deductible has been met. |
| **Removable Dentures**<br>(Full denture/partial denture)<br>Limited to a frequency of one every 60 months. | 40% co-insurance, after the medical deductible has been met. | 50% co-insurance, after the medical deductible has been met. |
| **Bridges (Fixed partial dentures)**<br>Limited to one time every 60 months. | 40% co-insurance, after the medical deductible has been met. | 50% co-insurance, after the medical deductible has been met. |
| **Implant Procedures**<br>Limited to one time every 60 months. | 40% co-insurance, after the medical deductible has been met. | 50% co-insurance, after the medical deductible has been met. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Dental - Pediatric Medically Necessary Orthodontics** | | |
| Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies. | 40% co-insurance, after the medical deductible has been met. | 50% co-insurance, after the medical deductible has been met. |
| | Prior Authorization is required for orthodontic treatment. | Prior Authorization is required for orthodontic treatment. |
| **Dental Services - Accident Only** | | |
| | You pay nothing, after the medical deductible has been met. | You pay nothing, after the network medical deductible has been met. |
| **Diabetes Services** | | |
| Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care: | The amount you pay is based on where the covered health care service is provided. | |
| Diabetes Self-Management Items: | The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Rider. | |
| | | Prior Authorization is required for DME that costs more than $1,000. |
| **Durable Medical Equipment (DME), Orthotics and Supplies** | | |
| | $90 co-pay per item, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| | | Prior Authorization is required for DME or orthotics that costs more than $1,000. |
| **Emergency Health Care Services - Outpatient** | | |
| Emergency Room: | $500 co-pay per visit, after the medical deductible has been met. | $500 co-pay per visit, after the network medical deductible has been met. |
| Emergency Room Physician: | You pay nothing, after the medical deductible has been met. | You pay nothing, after the network medical deductible has been met. |
| | | Notification is required if confined in an Out-of-Network Hospital. |
| **Gender Dysphoria** | | |
| | The amount you pay is based on where the covered health care service is provided and as stated in the Outpatient Prescription Drug Rider. | |
| | Prior Authorization is required for certain services. | Prior Authorization is required for certain services. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Habilitative Services** | | |
| Inpatient: | The amount you pay is based on where the covered health care service is provided. | |
| Outpatient:<br>Outpatient therapies are limited per year as follows:<br>20 visits of physical therapy.<br>20 visits of occupational therapy.<br>20 visits of speech therapy.<br>30 visits of post-cochlear implant aural therapy.<br>20 visits of cognitive therapy. | $90 co-pay per visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required for certain Inpatient services. |
| **Hearing Aids** | | |
| Limited to a single purchase per hearing impaired ear every three years. Repair and replacement of a hearing aid would apply in the same manner as a purchase. | $90 co-pay per device, after the medical deductible has been met. | Out-of-Network Benefits are not available. |
| **Home Health Care** | | |
| To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify. | You pay nothing, after the medical deductible has been met. | Out-of-Network Benefits are not available. |
| **Hospice Care** | | |
| | 20% co-insurance, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required for Inpatient Stay. |
| **Hospital - Inpatient Stay** | | |
| | $1,000 co-pay per Inpatient Stay, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met.<br><br>Prior Authorization is required. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Lab, X-Ray and Diagnostic - Outpatient** | | |
| Lab Testing - Outpatient:<br>Limited to 18 Presumptive Drug Tests per year.<br>Limited to 18 Definitive Drug Tests per year. | Outpatient:<br>$40 co-pay per service, after the medical deductible has been met. | Outpatient:<br>30% co-insurance, after the medical deductible has been met. |
| | Office:<br>You pay nothing for a primary care physician office visit. A deductible does not apply.<br>You pay nothing for a specialist office visit, after the medical deductible has been met. | Office:<br>30% co-insurance, after the medical deductible has been met. |
| X-Ray and Other Diagnostic Testing - Outpatient: | Outpatient:<br>$40 co-pay per service, after the medical deductible has been met. | Outpatient:<br>30% co-insurance, after the medical deductible has been met. |
| | Office:<br>You pay nothing for a primary care physician office visit. A deductible does not apply.<br>You pay nothing for a specialist office visit, after the medical deductible has been met. | Office:<br>30% co-insurance, after the medical deductible has been met. |
| | | Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services. |
| **Major Diagnostic and Imaging - Outpatient** | | |
| | $500 co-pay per service, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met.<br>Prior Authorization is required. |
| **Manipulative Treatment Services** | | |
| | Note: The first three visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any co-payment, co-insurance or deductible and subject to the annual visit limits. For all other visits, please see the payment information listed below.<br>$45 co-pay per visit. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Mental Health Care and Substance - Related and Addictive Disorders Services** | | |
| Inpatient: | $1,000 co-pay per Inpatient Stay, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| Outpatient: | $45 co-pay per visit. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| Partial Hospitalization/Intensive Outpatient Treatment: | You pay nothing, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| | | Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services. |
| **Ostomy Supplies** | | |
| | You pay nothing, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| **Phenylketonuria Treatment** | | |
| Professional medical services provided under the supervision of a Physician. | The amount you pay is based on where the covered health care service is provided. | |
| Special dietary formulas for the therapeutic treatment of phenylketonuria. | You pay nothing, after the medical deductible has been met or as stated under the Outpatient Prescription Drug Rider. | 30% coinsurance, after the medical deductible has been met or as stated under the Outpatient Prescription Drug Rider |
| | Prior Authorization is required. | Prior Authorization is required. |
| **Physician Fees for Surgical and Medical Services** | | |
| Physician House Calls: | $45 co-pay per visit for a primary care physician office visit. A deductible does not apply.<br>$90 co-pay per visit for a specialist office visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| Inpatient Facility Visits: | You pay nothing, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| Outpatient Facility Visits: | You pay nothing, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Physician's Office Services - Sickness and Injury** | | |
| Office Visit: | $45 co-pay per visit for a primary care physician office visit. A deductible does not apply.<br><br>$90 co-pay per visit for a specialist office visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| Office Surgery: | $45 co-pay per date of service for a primary care physician office visit. A deductible does not apply.<br><br>$90 co-pay per date of service for a specialist office visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| Injections, other than Allergy Injections: | 20% co-insurance per injection, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |

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

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Pregnancy - Maternity Services** | | |
| | The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. | |
| | | Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. |
| **Prescription Drug Benefits** | | |
| Prescription drug benefits are shown in the Prescription Drug benefit summary. | | |
| **Preventive Care Services** | | |
| Physician Office Services, Lab, X-Ray or other preventive tests. | You pay nothing. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |

Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Prosthetic Devices** | | |
| | $90 co-pay per device, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met.<br>Prior Authorization is required for Prosthetic Devices that costs more than $1,000. |
| **Reconstructive Procedures** | | |
| | The amount you pay is based on where the covered health care service is provided. | |
| | | Prior Authorization is required. |
| **Rehabilitation Services - Outpatient Therapy** | | |
| Limited per year as follows:<br>36 visits of pulmonary rehabilitation therapy.<br>36 visits of cardiac rehabilitation therapy.<br>20 visits of physical therapy.<br>20 visits of occupational therapy.<br>20 visits of speech therapy.<br>30 visits of post-cochlear implant aural therapy.<br>20 visits of cognitive rehabilitation therapy. | Note: The first three visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any co-payment, co-insurance or deductible and subject to the annual visit limits. For all other visits, please see the payment information listed below.<br>$90 co-pay per visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| **Skilled Nursing Facility / Inpatient Rehabilitation Facility Services** | | |
| Skilled Nursing is limited to 100 days per year.<br>Covered Health Care Services in an Inpatient Rehabilitation Facility are not subject to an annual limit. | 20% co-insurance, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met.<br>Prior Authorization is required. |
| **Surgery - Outpatient** | | |
| | $500 co-pay per date of service, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met.<br>Prior Authorization is required for certain services. |
| **Telemedicine Services** | | |
| | The amount you pay is based on where the covered health care service is provided. | |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Temporomandibular Joint (TMJ) Services** | | |
| | The amount you pay is based on where the covered health care service is provided. | |
| | | Prior Authorization is required for an Inpatient Stay. |
| **Therapeutic Treatments - Outpatient** | | |
| Radiation Therapy and Intravenous Chemotherapy:<br><br>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology. | Facility:<br>20% co-insurance, after the medical deductible has been met.<br>Office Visit:<br>$45 co-pay per visit for a primary care physician office visit. A deductible does not apply.<br>$90 co-pay per visit for a specialist office visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| Renal Dialysis Services: | Facility:<br>20% co-insurance, after the medical deductible has been met.<br>Office Visit:<br>$45 co-pay per visit for a primary care physician office visit. A deductible does not apply.<br>$90 co-pay per visit for a specialist office visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| All Other Therapeutic Treatments: | Facility:<br>20% co-insurance, after the medical deductible has been met.<br>Office Visit:<br>$45 co-pay per visit for a primary care physician office visit. A deductible does not apply.<br>$90 co-pay per visit for a specialist office visit, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| | | Prior Authorization is required for certain services. |
| **Transplantation Services** | | |
| Network Benefits must be received from a Designated Provider. | The amount you pay is based on where the covered health care service is provided.<br><br>Prior Authorization is required. | Out-of-Network Benefits are not available. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Urgent Care Center Services** | | |
| | $50 co-pay per visit. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, lab work. | | |
| **Urinary Catheters** | | |
| | You pay nothing, after the medical deductible has been met. | 30% co-insurance, after the medical deductible has been met. |
| **Virtual Visits** | | |
| Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups. | You pay nothing. A deductible does not apply. | Out-of-Network Benefits are not available. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits | Your cost if you use Out-of-Network Benefits |
|---|---|---|
| **Vision - Pediatric Services (Benefits covered up to age 19)** | | |
| Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com. | | |
| **Routine Vision Exam**<br>Limited to once every 12 months. | $10 co-pay per visit. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| **Eyeglass Lenses**<br>Limited to once every 12 months. | $25 co-pay. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| **Lens Extras**<br>Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating. | You pay nothing. A deductible does not apply. | You pay nothing, after the medical deductible has been met. |
| **Eyeglass Frames**<br>Limited to once every 12 months. | | |
| Eyeglass frames with a retail cost up to $130. | You pay nothing. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| Eyeglass frames with a retail cost between $130 - 160. | $15 co-pay. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| Eyeglass frames with a retail cost between $160 - 200. | $30 co-pay. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| Eyeglass frames with a retail cost between $200 - 250. | $50 co-pay. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| Eyeglass frames with a retail cost greater than $250. | 40% co-insurance. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| **Contact Lenses/Necessary Contact Lenses**<br>You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.<br>Fitting and evaluation limited to once every 12 months.<br>Limited to a 12 month supply.<br>Find a complete list of covered contacts at myuhcvision.com. | $25 co-pay. A deductible does not apply. | 30% co-insurance, after the medical deductible has been met. |
| **Low Vision Care Services**<br>Limited to once every 24 months. | You pay nothing for Low Vision Testing. A deductible does not apply.<br>25% co-insurance for Low Vision Therapy. A deductible does not apply. | 25% co-insurance for Low Vision Testing, after the medical deductible has been met.<br>25% co-insurance for Low Vision Therapy, after the medical deductible has been met. |

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

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

UnitedHealthcare Insurance Company of the River Valley does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com

**Mail:** Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

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

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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