Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
International and U.S. Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	✓
Virtual Visits Talk to a doctor 24/7 who can diagnose and treat a wide range of non-emergency medical conditions, such as colds and rashes.	✓
Vision With this plan, you have coverage for an annual eye exam.	✓
Preventive care covered at 100% There is no additional cost to you for seeing an International or U.S. network provider for preventive care.	✓
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	✓
Evacuation & Repatriation With our program, you are covered for certain assistance benefits and services, including medical evacuations and repatriations.	✓
Intelligence The Global Intelligence Center provides real-time, country-specific medical and security details, risks, quality of care assessments, threats and immunizations requirements.	✓

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. 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.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	International	U.S. Network	U.S. Out-of-Network
Annual Medical Deductible			
Individual	You do not have to pay a medical deductible.	$1,000	$2,000
Family	You do not have to pay a medical deductible.	$3,000	$6,000

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

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit			
Individual	$2,000	$2,000	$3,000
Family	$6,000	$6,000	$9,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Any amount you pay for Covered Health Care Services applied to the International Out-of-Pocket Limit will be applied to the Network Out-of-Pocket Limit. Any amount you pay for Covered Health Care Services applied to the Network Out-of-Pocket Limit will be applied to the International Out-of-Pocket Limit. In addition, any amount you pay for Network Covered Health Care Services which do not have a International Benefit level will be applied to the International Out-of-Pocket Limit.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year. Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	International	U.S. Network	U.S. Out-of-Network
Preventive Care Services			
Preventive Care Services *Certain preventive care services are provided as specified 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 copay, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.*	No copay	No copay	30%*
Office Services - Sickness & Injury			
Primary Care Physician *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.*	No copay	$20 copay	30%*
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.*	No copay	$40 copay	30%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	International	U.S. Network	U.S. Out-of-Network
Urgent Care Center Services *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.*	No copay	$50 copay	30%*
Virtual Visits *Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card.*	No copay	No copay	Not covered
Vision Exams *Limited to 1 exam every 12 months.* *For U.S. Benefits find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.*	No copay	$20 copay	30%*
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance	10%	10%*	10%*
Ground Ambulance	10%	10%*	10%*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance	10%	10%*	10%*
Ground Ambulance	10%	10%*	30%*
Dental Services - Accident Only	10%	10%*	10%*
Emergency Health Care Services - Outpatient	No copay	$200 copay	$200 copay
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]	10%	10%*	30%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.		
Hospital - Inpatient Stay[1]	10%	10%*	30%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 120 days per year in a Skilled Nursing Facility.* *Covered Health Care Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.*	10%	10%*	30%*
Outpatient Care			
Acupuncture Services *Limited to 25 treatments per year.*	No copay	$20 copay	30%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	International	U.S. Network	U.S. Out-of-Network
Habilitative Services - Outpatient *For outpatient therapies (physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services.*	No copay	$20 copay	30%*
Home Health Care[1] *Limited to 120 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	10%	10%*	30%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1]	No copay	No copay	30%*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]	No copay	No copay	30%*
Major Diagnostic and Imaging - Outpatient[1]	10%	10%*	30%*
Physician Fees for Surgical and Medical Services	10%	10%*	30%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.* *Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of pervasive developmental disorder or Autism Spectrum Disorders.*	No copay	$20 copay	30%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*	10%	10%*	30%*
Surgery - Outpatient[1]	10%	10%*	30%*
Therapeutic Treatments - Outpatient[1]	10%	10%*	30%*
Supplies and Services			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	International	U.S. Network	U.S. Out-of-Network
Durable Medical Equipment (DME), Orthotics and Supplies[1] *Limited to a single purchase of a type of DME or orthotic every 3 years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*	10%	10%*	30%*
Hearing Aids *Limited to $5,000 every year. Benefits are further limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*	10%	10%*	30%*
Ostomy Supplies	10%	10%*	30%*
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*	10%	10%*	30%*
Prosthetic Devices[1]	10%	10%*	30%*
Pregnancy			
Pregnancy - Maternity Services[1] *All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care Act, will be provided without cost share. Please refer to Preventive Care Services below.* *Prenatal care office visits received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy.* *We pay for Covered Health Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.*	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.		
Mental Health Care & Substance Related and Addictive Disorder Services			
All Other Outpatient Treatment[1]	10%	10%*	30%*
Inpatient[1]	10%	10%*	30%*
Outpatient Office Visits[1]	No copay	$20 copay	30%*
Other Services			
Breast Cancer Services[1]	Benefits are not available.	The amount you pay is based on where the covered health care service is provided.	
Clinical Trials[1] *To be a qualifying clinical trial for services outside the United States, a clinical trial must meet all of the criteria as described under Clinical Trials in the Certificate of Coverage.*	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	International	U.S. Network	U.S. Out-of-Network
Culturally Based Services	10%	Benefits are not available	Benefits are not available
Dental Anesthesia Services *Limited to Covered Persons who are one of the following: a child under seven years of age; a person who is developmentally disabled regardless of age; or a person whose health is compromised and for whom general anesthesia is required, regardless of age.*	Benefits are not available.	10%*	30%*
Diabetes Treatment[1] *Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.*	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Prescription Drug Benefits Section.		
Fertility Preservation for Iatrogenic Infertility *Limited to $20,000 per Policy.* *Limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*	Benefits are not available.	10%*	30%*
Gender Dysphoria All Other Outpatient Office Visits *Outpatient prescription drugs for the treatment of gender dysphoria are subject to the cost share as noted in the Outpatient Prescription Drug Schedule of Benefits.*	10%	10%*	30%*
Gender Dysphoria Inpatient	10%	10%*	30%*
Gender Dysphoria Outpatient Office Visits	No copay	$20 copay	30%*
Home Test Kits for Sexually Transmitted Diseases	Benefits are not available.	10%*	30%*
Hospice Care[1]	10%	10%*	30%*
Mastectomy Services[1]	Benefits are not available.	The amount you pay is based on where the covered health care service is provided.	
Obesity - Weight Loss Surgery[1] *Obesity surgery is covered when received at a designated facility and performed by a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.*	The amount you pay is based on where the covered health care service is provided.		Not covered
Off-Label Drug Use and Experimental or Investigational Services	Benefits are not available.	The amount you pay is based on where the covered health care service is provided.	
Osteoporosis Services	Benefits are not available.	The amount you pay is based on where the covered health care service is provided.	
Prosthetic Devices - Laryngectomy[1]	Benefits are not available.	The amount you pay is based on where the covered health care service is provided.	
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Telehealth Services	Benefits are not available.	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services[1]	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	International	U.S. Network	U.S. Out-of-Network
Transplantation Services[1]	The amount you pay is based on where the covered health care service is provided.		Not covered
Wigs *Limited to $600 every 24 months.*	10%	10%*	30%*
Evacuation and Repatriation Services			
Emergency Evacuation[1] *Limited to a per diem of $300 for up to 30 days towards the living expenses incurred by the person(s) accompanying you.* *Services for Evacuation/Repatriation benefits are only covered if all arrangements are approved in advance and arranged by us.*	No copay	Benefits are not available	Benefits are not available
Emergency Family Reunion[1] *Limited to a per diem for living expenses for immediate family members of $300 while the Covered Person is hospitalized up to 30 days.* *Services for Evacuation/Repatriation benefits are only covered if all arrangements are approved in advance and arranged by us.*	No copay	Benefits are not available.	Benefits are not available
Medical Repatriation[1] *Benefits include Repatriation of Children (under age 18) and adult family members.* *Services for Evacuation/Repatriation benefits are only covered if all arrangements are approved in advance and arranged by us.*	No copay	Benefits are not available	Benefits are not available
Repatriation of Remains[1] *Benefits include Return of Children (under age 18) and adult family members.* *Services for Evacuation/Repatriation benefits are only covered if all arrangements are approved in advance and arranged by us.*	No copay	Benefits are not available.	Benefits are not available
International Pharmacy Benefits			
Outpatient Prescription Drugs *Prescriptions must be paid for out-of-pocket and submitted to us for reimbursement.*	10%	Benefits are not available	Benefits are not available

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

U.S. Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

U.S. In Network and Out of Network

Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	U.S. Retail Network	U.S. Out-of-Network Pharmacy	U.S. Mail Order Network Pharmacy**
Tier 1 $	$20	20%	$50
Tier 2 $$	$40	20%	$100
Tier 3 $$$	$75	20%	$187.50

* After the Annual Pharmacy Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

For members that need to take their prescription drugs with them outside the United States, up to 365 day supply may be obtained with a prescription from a Network provider. Certain limitations may apply, such as controlled narcotics or drugs with a limited shelf-life.

Other important information about your benefits.

Medical Exclusions

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.

- Cosmetic Surgery
- Glasses
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

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

Other important information about your benefits.

Pharmacy Exclusions

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

- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental or Investigational or Unproven Services and medications.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Prescription Drug Products when prescribed to treat infertility unless required by state law.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Drugs available over-the-counter.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.

UnitedHealthcare does 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:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 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**, **1-800-537-7697** (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. 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.

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 русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المدرج على بطاقة العضوية الخاصة بك.

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.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά **(Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

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

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

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

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

UnitedHealthcare Global

B2C 9183517.0 11/19 DBID : 383961 19-12550

UnitedHealthcare dental plan

Options PPO/covered dental services Standard GS101/CS0

	NON-ORTHODONTICS		ORTHODONTICS	
	INTERNATIONAL/NETWORK	NON-NETWORK	INTERNATIONAL/NETWORK	NON-NETWORK
Individual Annual Calendar Year Deductible	$0	$0	$0	$0
Family Annual Calendar Year Deductible	$0	$0	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	$2,000 per person per Calendar Year	$2,000 per person per Calendar Year	$2,000 per person per lifetime	

New enrollee's waiting period:	None
Annual deductible applies to preventive and diagnostic services	No (In Network)- No (Out Network)
Annual deductible applies to orthodontic services	No
Orthodontic eligibility requirement	Children (to age 19)

COVERED SERVICES*	INTERNATIONAL/ NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Plan Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.
BASIC SERVICES			
Restorations (Amalgam or Anterior Composite)*	80%	80%	Multiple restorations on one surface will be treated as a single filling.
Emergency Treatment / General Services	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	80%	80%	
Periodontics	80%	80%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns*	80%	80%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	80%	80%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	80%	80%	Once per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Course of treatment is typically 24 months, with the initial payment at banding of 20% and remaining payment spread over the course of the treatment

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

The Prenatal Dental Care and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

General Limitations

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Panorex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

BITEWING RADIOGRAPHS Limited to 1 series of films per Plan Year

EXTRAORAL RADIOGRAPHS Limited to 2 films per Plan Year

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation

RESTORATIONS Multiple restorations on 1 surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant, per consecutive 24 months.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribe to control habitual grinding.

FULL MOUTH DEBRIDMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only when clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

General Exclusions

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
13. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the policy for 12 continuous months.
14. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
15. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
16. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
17. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
18. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
19. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
20. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
21. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
22. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia
24. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
25. Charges for failure to keep a scheduled appointment without giving the dental office 24-hour notice.
26. Occlusal guard used as safety items or to affect performance primarily in sports-related activities
27. Dental 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.
28. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Vision Benefit Summary
Powered by UnitedHealthcare Vision Network
Customer Service and Provider Locator: (800) 638-3120
myuhcvision.com

Plan VGS01

UnitedHealthcare Vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses instead of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 0.00
Eyeglasses (lenses and frame)	$ 0.00
Contact lenses instead of Eyeglasses	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating, Tint, UV Coating, Progressive Tier I, Progressive Tier II, Polycarbonate Lenses for Dependent Children (up to age 19), Polycarbonate Lenses for Adults – covered in full.	
Contact Lens Benefit[2] (Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Non-Formulary. A copy of the list can be found at myuhcvision.com).	
Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.	If you choose disposable contacts, up to 6 boxes are included when obtained from an in-network provider.
Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. Contact lens copay is waived.	$150.00
Necessary contact lenses [3]	Covered in full after copay (if applicable).
Children's and Maternity Eye Care Benefit	
Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame, and lens benefits.	

Out-of-Network Reimbursements	U.S. Non-Network Benefits	International Benefits*
Exam(s)	Up to $40.00	Up to $ 80.00
Frames	Up to $45.00	Up to $110.00
Single Vision Lenses	Up to $40.00	Up to $ 60.00
Lined Bifocal and Progressive Lenses	Up to $60.00	Up to $ 80.00
Lined Trifocal Lenses	Up to $80.00	Up to $115.00
Lenticular Lenses	Up to $80.00	Up to $130.00
Elective Contacts instead of Eyeglasses[2]	Up to $105.00	Up to $150.00
Necessary Contacts instead of Eyeglasses[3]	Up to $210.00	Up to $210.00

United Healthcare Global

Discounts	
	Laser vision UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction providers. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare Vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.

[2]Contact lenses are instead of eyeglass lenses and/or eyeglass frames. Coverage for Formulary contact lenses does not apply at all in-network providers. The allowance for Non-Formulary contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.

[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

*International Benefits receive out of network only. No other benefits or patient options are to be administered.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare Vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare Formulary.
- Patient lens options which are not covered-in-full may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.

ChoiceandAccessofVisionCareProviders

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider, or print an ID card online at myuhcvision.com.

Retain this UnitedHealthcare Vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.

In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

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