

What is a benefit summary?

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

What are the benefits of the UnitedHealthcare Choice Direct Plan?

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

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

- > **Pay less by using certain freestanding centers.** Freestanding centers are health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.
- > **Save money by staying in our network.** If you don't use the network, you'll have to pay for all of the costs.
- > **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.
- > **Preventive care is covered 100% in our network.**

Are you a member?

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

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

Not enrolled yet? 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.

Benefits At-A-Glance

What you may pay for network care

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

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
\$50	\$2,000	30%

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

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

Annual Deductible

What is an annual deductible?

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

- > Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.
- > All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.
- > This benefit plan includes a per occurrence deductible that applies to certain covered health care services. This per occurrence deductible must be met prior to and in addition to the medical deductible.

Medical Deductible - Individual	\$2,000 per year
Medical Deductible - Family	\$4,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.

Out-of-Pocket Limit

What is an out-of-pocket limit?

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

- > All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.
- > Your co-pays, co-insurance, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	\$7,300 per year
Out-of-Pocket Limit - Family	\$14,600 per year

Your Costs

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

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

Covered Health Care Services

Your cost if you use Network Benefits

Ambulance Services

Emergency Ambulance	30% co-insurance, after the medical deductible has been met.
Non-Emergency Ambulance	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.

Blood and Blood Products

30% co-insurance, after the medical deductible has been met.

Case Management Services

The amount you pay is based on where the covered health service is provided.

Chiropractic Services

Limited to 20 visits per condition per year.	\$50 co-pay per visit. A deductible does not apply.
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Controlled Clinical Trials

The amount you pay is based on where the covered health service is provided.

Prior Authorization is required.

Dental - Pediatric Services (Benefits covered up to age 19)

Benefits provided by the National Options PPO 20 Network (INO-MAC).

Dental - Pediatric Preventive Services

Dental Prophylaxis (Cleanings) Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.
Space Maintainers (Spacers)	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Dental - Pediatric Diagnostic Services

Evaluations (Check-up Exams)

You pay nothing, after the medical deductible has been met.

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.

Intraoral Radiographs (X-ray)

You pay nothing, after the medical deductible has been met.

Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.

Dental - Pediatric Basic Dental Services

Endodontics (Root Canal Therapy)

20% co-insurance, after the medical deductible has been met.

Adjunctive Services

20% co-insurance, after the medical deductible has been met.

Palliative (Emergency) Treatment:

Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit.

General Anesthesia: Covered only when clinically Necessary.

Occlusal Guard: Limited to one guard every 12 months.

Oral Surgery

20% co-insurance, after the medical deductible has been met.

Periodontics

20% co-insurance, after the medical deductible has been met.

Periodontal Surgery: Limited to one every 36 months per surgical area.

Scaling and Root Planing: Limited to one time per quadrant every 24 months.

Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis.

Minor Restorative Services (Amalgam or Anterior Composite)

20% co-insurance, after the medical deductible has been met.

Simple Extractions (Simple tooth removal)

20% co-insurance, after the medical deductible has been met.

Limited to one time per tooth per lifetime.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Dental - Pediatric Major Restorative Services

Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.

Dental - Pediatric Medically Necessary Orthodontics

Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for orthodontic treatment.

Dental Services - Accident Only

30% co-insurance, after the medical deductible has been met.
Prior Authorization is required.

Dental Services - Hospital and Ambulatory Facility Charges Related to Dental Care

Inpatient:	30% co-insurance, after the medical deductible has been met.
Outpatient:	\$100 co-pay per visit for a specialist office visit. A deductible does not apply.

Detoxification Services

Inpatient:	30% co-insurance, after the medical deductible has been met.
Outpatient:	\$50 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing. A deductible does not apply.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Diabetes Services

Diabetes Self Management and Training/Diabetic Eye Exams/Foot Care:

The amount you pay is based on where the covered health care service is provided.

Diabetes Self Management Items:

The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Schedule or Certificate of Coverage.

Durable Medical Equipment (DME), Orthotics and Supplies

30% co-insurance, after the medical deductible has been met.

Emergency Health Care Services - Outpatient

30% co-insurance, after the medical deductible has been met.

Family Planning Services

\$50 co-pay per visit for a primary care physician office visit. A deductible does not apply.

Gender Dysphoria

The amount you pay is based on where the covered health care service is provided.

Prior Authorization is required for certain services.

Habilitative Services

Inpatient:

The amount you pay is based on where the covered health care service is provided.

Outpatient:

\$50 co-pay per visit. A deductible does not apply.

Outpatient therapies are limited per year as follows:

Unlimited for Covered Persons up to age 19.

For Covered Persons age 19 or older, limited to:

30 visits of physical therapy visits per condition.

30 visits of occupational therapy visits per condition.

30 visits of speech therapy visits per condition.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Hearing Aids

Limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.

30% co-insurance, after the medical deductible has been met.

Home Health Care

30% co-insurance, after the medical deductible has been met.

Hospice Care

30% co-insurance, after the medical deductible has been met.

Hospital - Inpatient Stay

30% co-insurance, after the medical deductible has been met.

Infertility Services

30% co-insurance, after the medical deductible has been met.

Lab, X-Ray and Diagnostic - Outpatient

Lab Testing - Outpatient

30% co-insurance, after the medical deductible has been met for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office.

30% co-insurance, after the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center.

X-Ray and Other Diagnostic Testing - Outpatient

30% co-insurance, after the medical deductible has been met for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office.

30% co-insurance, after the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center.

Major Diagnostic and Imaging - Outpatient

\$300 per occurrence deductible per service for services provided at a freestanding diagnostic center or in a physician's office. An annual deductible does not apply.

30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Medical Foods

30% co-insurance, after the medical deductible has been met.

Mental Health Care and Substance - Related and Addictive Disorders Services

Inpatient: 30% co-insurance, after the medical deductible has been met.

Outpatient: \$50 co-pay per visit. A deductible does not apply.

Partial Hospitalization/Intensive
Outpatient Treatment: You pay nothing. A deductible does not apply.

Nutritional Services and Medical Nutrition Therapy

\$50 co-pay per visit for a primary care physician office visit. A deductible does not apply.

Pharmaceutical Products - Outpatient

This includes medications given at a doctor's office, or in a Covered Person's home. 30% co-insurance, however you will never pay more than \$150 per 30 day supply for a Specialty Prescription Drug Product, after the medical deductible has been met.

Physician Fees for Surgical and Medical Services

30% co-insurance, after the medical deductible has been met.

Physician's Office Services - Sickness and Injury

\$50 co-pay per visit for a primary care physician office visit. A deductible does not apply.

\$100 co-pay per visit for a specialist office visit. A deductible does not apply.

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

Pregnancy - Maternity Services

The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

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.

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

Prosthetic Devices

30% co-insurance, after the medical deductible has been met.

Reconstructive Procedures

The amount you pay is based on where the covered health care service is provided.

Rehabilitation Services - Outpatient Therapy

Limited to:

\$50 co-pay per visit. A deductible does not apply.

90 visits of cardiac rehabilitation per therapy (physical, speech, occupational).

30 visits of physical therapy per condition.

30 visits of occupational therapy per condition.

30 visits of speech therapy per condition.

One program per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy for pulmonary rehabilitation therapy.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.

\$300 per occurrence deductible per date of service for services provided at a freestanding center or in a physician's office. An annual deductible does not apply.

30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.

Skilled Nursing Facility / Inpatient Rehabilitation Facility Services

Limited to 100 days per year when admitted to a Skilled Nursing Facility.

30% co-insurance, after the medical deductible has been met.

Surgery - Outpatient

\$300 per occurrence deductible per date of service for services provided at an ambulatory surgical center or in a physician's office. An annual deductible does not apply.

30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Surgical Morbid Obesity Treatment

For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.

The amount you pay is based on where the covered health service is provided.

Therapeutic Treatments - Outpatient

Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.

\$300 co-pay per treatment. A deductible does not apply.

Transplantation Services

Network Benefits must be received from a Designated Provider.

The amount you pay is based on where the covered health service is provided.

Prior Authorization is required.

Urgent Care Center Services

\$50 co-pay per visit. A deductible does not apply.

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

Virtual Visits

Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com[®] or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

\$10 co-pay per visit. A deductible does not apply.

Your Costs

Covered Health Care Services

Your cost if you use 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 \$30 co-pay per visit. A deductible does not apply.

Limited to once every 12 months.

Eyeglass Lenses 50% co-insurance. A deductible does not apply.

Limited to once every 12 months.

Lens Extras You pay nothing. A deductible does not apply.

Limited to once every 12 months.

Coverage includes polycarbonate lenses and standard scratch-resistant coating.

Eyeglass Frames

Limited to once every 12 months.

Eyeglass frames with a retail cost up to \$130. 50% co-insurance. A deductible does not apply.

Eyeglass frames with a retail cost between \$130 - 160. 50% co-insurance. A deductible does not apply.

Eyeglass frames with a retail cost between \$160 - 200. 50% co-insurance. A deductible does not apply.

Eyeglass frames with a retail cost between \$200 - 250. 50% co-insurance. A deductible does not apply.

Eyeglass frames with a retail cost greater than \$250. 50% co-insurance. A deductible does not apply.

Contact Lenses/Necessary Contact Lenses 50% co-insurance. A deductible does not apply.

You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Fitting and evaluation limited to once every 12 months.

Limited to a 12 month supply.

Find a complete list of covered contacts at myuhcvision.com.

Low Vision Care Services

You pay nothing for Low Vision Testing. A deductible does not apply.

Limited to comprehensive low vision examination once every 5 years, including 4 follow-up visits in any 5-year period.

25% co-insurance for Low Vision Therapy. A deductible does not apply.

Services your plan does not cover (Exclusions)

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

Services that are not Medically Necessary.

Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.

Services that are beyond the scope of practice of a Health Care Practitioner performing the service.

Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable.

Services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.

The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or Injury. This exclusion does not apply to the Benefits provided for pediatric vision as described in the Pediatric Vision Care Services Rider.

Personal Care services and Domiciliary Care services.

Services rendered by a Health Care Practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother, or sister.

Experimental Services. This exclusion does not apply to the off-label use of a Prescription Drug Product if such Prescription Drug Product is recognized for treatment in any of the standard reference compendia or in the medical literature.

Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

Services to reverse a voluntary sterilization procedure.

Services for sterilization or reverse sterilization for a dependent minor. This exclusion does not apply to U.S. Food and Drug Administration (FDA) approved sterilization procedures for women with reproductive capacity.

Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in Section 1 of the COC.

Services incurred before the effective date of coverage for a Covered Person.

Services incurred after a Covered Person's termination of coverage, including any services rendered during any extension of benefits period.

Surgery or related services for Cosmetic Procedures to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or Congenital or developmental Anomalies.

Services for Injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a workers' compensation law.

Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.

Inpatient admissions primarily for diagnostic studies, unless authorized by us.

Except for covered ambulance services, travel, whether or not recommended by a Health Care Practitioner. This exclusion does not apply to travel for transplantation services for which Benefits are provided as described in Section 1 of the COC under Transplantation Services.

Except for Emergency Health Services, services received while the Covered Person is outside the United States.

Immunizations related to foreign travel.

Unless otherwise specified in Section 1 of the COC or in the Pediatric Dental Services Rider, dental work or treatment which includes hospital or professional care in connection with:

- The operation or treatment for the fitting or wearing of dentures,

Services your plan does not cover (Exclusions)

- Orthodontic care or malocclusion,
- Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if treatment is started within six months of the accident, or if not a Covered Person at the time of the accident, within the first six months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care); and
- Dental implants.

Accidents occurring while and as a result of chewing. This exclusion does not apply to the Benefits provided for pediatric dental services as described in the Pediatric Dental Services Rider.

Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary.

Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary.

Inpatient admissions primarily for physical therapy, unless authorized by us.

Treatment leading to or in connection with transexualism, or sex changes or modifications, including but not limited to surgery.

Treatment of sexual dysfunction not related to organic disease.

Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.

Nonhuman organs and their implantation.

Nonreplacement fees for blood and blood products.

Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a Covered Service.

Wigs or cranial prosthesis.

Weekend admission charges, except for emergencies and maternity, unless authorized by us.

Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.

Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or Injury.

Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.

Services for, or related to, the removal of an organ from a covered person for purposes of transplantation into another person, unless the:

- Transplant recipient is covered under the plan and is undergoing a covered transplant, and
- Services are not payable by another carrier.

Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

Private hospital room, unless authorized by us.

Private Duty Nursing, unless authorized by us.

Treatment for Mental Health or Substance Use Disorder Services for the following:

- Services by pastoral or marital counselors.
- Therapy for sexual problems.
- Treatment for learning disabilities or intellectual disabilities.
- Telephone therapy.
- Travel time to the Covered Person's home to conduct therapy.
- Services rendered or billed by a school, or halfway houses or members of their staff.
- Marriage counseling.

Services your plan does not cover (Exclusions)

- Services that are not Medically Necessary.

Cardiac rehabilitation therapy and pulmonary rehabilitation therapy services provided at a place of service that is not equipped and approved to provide such therapies.

Cardiac rehabilitation therapy and pulmonary rehabilitation therapy provided as maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the Maryland Health Occupations Article.

Services your plan does not cover (Exclusions)

Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. Any Dental Procedure not directly related with dental disease. This exclusion does not apply to preventive, diagnostic or orthodontic Dental Services. Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. This exclusion does not apply to the following when such Benefits are not provided under your medical coverage: Radical Excision - Lesion Diameter up to 1.25 cm; Excision of Malignant Tumor- Lesion Diameter up to 1.25 cm; Removal of Odontogenic Cyst or Tumor- Lesion Diameter up to 1.25 cm; Removal of Odontogenic Cyst or Tumor- Lesion Diameter greater than 1.25 cm; Removal of Non-odontogenic Cyst or Tumor- Lesion Diameter up to 1.25 cm; and Removal of Non-odontogenic Cyst or Tumor- Lesion Diameter greater than 1.25 cm. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. This exclusion does not apply to Benefits provided for services related to temporomandibular joint disorder. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Rider to the Policy. Dental Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy ends. This exclusion does not apply to Benefits provided as described above under Benefits after Coverage Termination for Dental Services. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child. Foreign Services are not covered unless required as an Emergency. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO). Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the Maryland Health Occupations Article. Dental Services received from an out-of-Network Dental Provider.

Services your plan does not cover (Exclusions)

Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the COC. Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Optional Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the Maryland Health Occupations Article. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.

For Internal Use only:

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MAMSI Life and Health Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف 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)**, udostępniłiśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री फोन नंबर पर काल करें।

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**khmer (Khmer)** សេវាជំនួយភាសាខ្មែរឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខគិតគំរៃថ្លៃ 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 yánit'i'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shqoqí ninaaltsoos nit'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodílnih.

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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