UnitedHealthcare®

Benefit Summary

Texas - Insurance Choice Plus
Premier - Plan BCYF

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 Tiered Benefit Plus 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 or out of our network, but you can save more money when you use the network. You can save even more when you use UnitedHealth Premium® Tier 1 providers.

> **Pay less by using UnitedHealth Premium Tier 1 providers.** They have been recognized for providing value.

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

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

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

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

Are you a member?

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

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

Benefits At-A-Glance

What you may pay for network care

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

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$30	$2,000	20%

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

Your Costs

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

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

What is an annual deductible?

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

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

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

Medical Deductible - Individual	$2,000 per year	$5,000 per year
Medical Deductible - Family	$4,000 per year	$10,000 per year

Out-of-Pocket Limit

What is an out-of-pocket limit?

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

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

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

Out-of-Pocket Limit - Individual	$6,000 per year	$10,000 per year
Out-of-Pocket Limit - Family	$12,000 per year	$20,000 per year

Your Costs

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

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

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acquired Brain Injury		
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	The amount you pay is based on where the covered health care service is provided.	
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services	$30 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Ambulance Services		
Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Amino Acid-Based Elemental Formulas		
Benefits under this category will be provided for any Medically Necessary services that are provided in connection with the administration of the formula. Benefits for the amino acid-based elemental formulas will be provided as described under the Outpatient Prescription Drug Rider.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Cellular and Gene Therapy		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Congenital Heart Disease (CHD) Surgeries		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Accident Only		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
Developmental Delay Services		
Benefits are paid at the same level as Benefits for any other Covered Health Service, except that the Benefit limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to services for developmental delays.	The amount you pay is based on where the covered health care service is provided.	
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: Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Rider.	Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
Limited to a single purchase of a type of DME or orthotic every three 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.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for DME or orthotics that costs more than $1,000.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Emergency Health Care Services - Outpatient		
	20% co-insurance after you pay the $250 co-pay per visit. A deductible does not apply.	20% co-insurance after you pay the $250 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: 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.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment. Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code.	$30 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain Inpatient services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-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.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 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. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings		
	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Major Diagnostic and Imaging - Outpatient		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.
Osteoporosis Detection and Prevention		
	The amount you pay is based on where the covered health care service is provided.	
Ostomy Supplies		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) and Other Heritable Diseases		
	The amount you pay is based on where the covered health care service is provided.	

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician Fees for Surgical and Medical Services		
	Designated Network: 20% co-insurance for primary care visits, after the medical deductible has been met. 20% co-insurance for specialist care visits, after the medical deductible has been met. Network: 20% co-insurance for primary care visits, after the medical deductible has been met. 20% co-insurance for specialist care visits, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician's Office Services - Sickness and Injury		
A deductible does not apply to diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.	Covered persons less than age 19: Designated Network: You pay nothing for a primary care physician office visit. A deductible does not apply. All other Covered Persons: Designated Network: $30 co-pay per visit for a primary care physician office visit. A deductible does not apply. Covered persons less than age 19: Network: You pay nothing for a primary care physician office visit. A deductible does not apply. All other Covered Persons: Network: $30 co-pay per visit for a primary care physician office visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
A deductible does not apply to diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.	Designated Network: $30 co-pay per visit for a specialist office visit. A deductible does not apply. Network: $60 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.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of Manipulative Treatments. Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code.	$30 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Surgery - Outpatient		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telehealth and Telemedicine Services		
	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular (TMJ) Joint Services		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits, services must be received at a Designated Provider. We will refer you to the Designated Provider most suitable, in our opinion, to treat your condition. In the event that the selected Designated Provider is located outside of Texas and you do not wish to travel outside the state, we shall refer you to an alternate Designated Provider within the State of Texas.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Urgent Care Center Services		
	$75 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

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

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

For Internal Use only:
TXCAB40BCYF19

Item#	**Rev. Date**	
275-12446	0319	UHPD/Sep/Emb/41298/2018

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

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug Products

Texas Plan IU

Standard Drugs: 15/40/75

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. 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.

Annual Drug Deductible	
Individual Deductible	No Deductible
Family Deductible	No Deductible
Out-of-Pocket Drug Limit	
Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

Tier Level	Up to 31-day supply	Up to 90-day supply
	Retail **Network Pharmacy or Preferred Specialty Network Pharmacy**	***Mail Order** **Network Pharmacy or Preferred 90 Day Retail Network Pharmacy****
Tier 1 Prescription Drug Products	**$15**	**$37.50**
Tier 2 Prescription Drug Products	**$40**	**$100**
Tier 3 Prescription Drug Products	**$75**	**$187.50**

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

* 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. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

**You will be charged a retail Co-payment and/or Co-insurance 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.

Other Important Information about your Outpatient Prescription Drug Benefits

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or 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 applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, 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 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. When a step therapy requirement applies to a Prescription Drug Product your provider may request an exception. For non-urgent step therapy exception requests, a review will be completed within 72 hours once all information needed to process the request has been received. If the exception request is not denied within 72 hours, then the request will be considered granted. For urgent step therapy exception requests, a review will be completed within 24 hours once all the information needed to process the request has been received. If the exception request is not denied within 24 hours, then the request will be considered granted. If your step therapy exception request is denied, the denial may be subject to an expedited appeal. Please refer to Section 6 of the COC for additional information on appealing an Adverse Determination.

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 Specialty Prescription Drug Products, we may direct you pharmacies with whom we have an arrangement to provide those Specialty Prescription Drug Products. If you are directed to such pharmacies and you choose not to obtain your Specialty Prescription Drug Product from one of these pharmacies, no Benefit will be paid for that Specialty Prescription Drug Product.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at myuhc.com® or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Certain Preventive Care Medications may be covered. 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.

PHARMACY EXCLUSIONS

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

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Policy anniversary date, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Policy anniversary date, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations will occur no more often than annually on the Policy anniversary date, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will apply to any off-label drug that is excluded from coverage under this Rider as well as any drug that the U.S. Food and Drug Administration (FDA) has determined to be contraindicated for the treatment of the disease or condition. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or Life-Threatening Disease or Condition if the drug is both of the following: has been approved by the FDA for at least one indication; and is recognized for treatment of the indication for which the drug is prescribed in either of the following: a prescription drug reference compendium approved by the commissioner of the Texas Department of Insurance; and substantially accepted peer-reviewed medical literature.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used for cosmetic purposes.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for tobacco cessation.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter items for which Benefits are available as described in the Certificate under Diabetes Services in Section 1 of the COC.
- 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. This exclusion does not apply to: Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in Section 1 of the COC; Amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC; and Formulas for phenylketonuria (PKU) or other heritable diseases.

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

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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