UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

California - Select Plus
Balanced - 35/5900/100% Plan AB5N

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	$5,900 per year	$11,800 per year
Family Deductible	$11,800 per year	$23,600 per year

> Copayments do not accumulate towards the Deductible unless otherwise notated within the specific Benefit category below.

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

Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	$6,350 per year	$12,700 per year
Family Out-of-Pocket Maximum	$12,700 per year	$25,400 per year

> 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.

> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

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UnitedHealthcare Insurance Company

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid. In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services.

> When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services		
Primary Physician Office Visit The number of visits for which a copayment will apply are combined with any Specialist Physician Office visits.	100% after you pay a $35 Copayment per visit for the first 3 visits in a year; 100% after Deductible has been met for any subsequent visits in that year.	50% after Deductible has been met.
Specialist Physician Office Visit The number of visits for which a copayment will apply are combined with any Primary Physician Office visits.	100% after you pay a $35 Copayment per visit for the first 3 visits in a year; 100% after Deductible has been met for any subsequent visits in that year.	50% after Deductible has been met. *Prior Authorization is required for Genetic Testing - BRCA.*

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100%, Copayments and Deductibles do not apply.	Non-Network Benefits are not available.
Specialist Physician Office Visit	100%, Copayments and Deductibles do not apply.	
Lab, X-Ray or other preventive tests	100%, Copayments and Deductibles do not apply.	

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Urgent Care Center Services		
	100% after Deductible has been met.	50% after Deductible has been met.
Emergency Health Services - Outpatient		
	100% after Deductible has been met.	100% after Network Deductible has been met. *Notification is required if confined in a non-Network Hospital.*

Types of Coverage	Network Benefits	Non-Network Benefits
Hospital - Inpatient Stay		
	100% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	100% after Deductible has been met.	100% after Network Deductible has been met.
Air Ambulance	100% after Deductible has been met.	100% after Network Deductible has been met.
	Prior Authorization is required for non-Emergency Ambulance.	*Prior Authorization is required for non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	100% after Deductible has been met.	50% after Deductible has been met.
		Prior Authorization is required.
Dental Services - Accident Only		
	100% after Deductible has been met.	100% after Network Deductible has been met.
	Prior Authorization is required.	*Prior Authorization is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required for Durable Medical Equipment in excess of $1,000.
Durable Medical Equipment		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	100% after Deductible has been met.	50% after Deductible has been met.
		Prior Authorization is required for Durable Medical Equipment in excess of $1,000.
Habilitative Services		
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.	
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are further limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	100% after Deductible has been met.	50% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 100 visits per year	100% after Deductible has been met.	50% after Deductible has been met.
		Prior Authorization is required.

Types of Coverage	Network Benefits	Non-Network Benefits
Hospice Care		
	100% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for Inpatient Stay.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	100% Deductible does not apply.	50% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	100% Deductible does not apply.	50% after Deductible has been met. *Prior Authorization is required for sleep studies.*
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	100% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required.*
Ostomy Supplies		
	100% after Deductible has been met.	50% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	100% after Deductible has been met.	50% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	100% after Deductible has been met.	50% after Deductible has been met.
Pregnancy - Maternity Services		
We pay for Covered Health Services incurred if you participate in the Expanded Alpha Feto Protein (AFP) program, a statewide prenatal testing program administered by the State Department of Health Services.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary 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 Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Prosthetic Devices		
	100% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for Prosthetic Devices in excess of $1,000.*
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Prior Authorization is required.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 24 visits of Manipulative Treatments 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy	100% after you pay a $35 Copayment per visit.	50% after Deductible has been met. *Prior Authorization is required for certain services.*
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	100% after Deductible has been met.	50% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	100% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required.*
Surgery - Outpatient		
	100% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for certain services.*
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	100% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required for certain services.*

Types of Coverage	Network Benefits	Non-Network Benefits
Transplantation Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For Network Benefits, services must be received at a Designated Facility. *Prior Authorization is required.*	Non-Network Benefits are not available.
Routine Vision Examination		
You may access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com Benefits are limited as follows: 1 exam every 24 months	100% after you pay a $30 Copayment per visit.	Non-Network Benefits are not available.

Types of Coverage	Network Benefits	Non-Network Benefits
Breast Cancer Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization is required.	*Prior Authorization is required.*
Dental Anesthesia Services		
Services are 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. A person whose health is compromised and for whom general anesthesia is required, regardless of age.	100% after Deductible has been met.	50% after Deductible has been met.
	Prior Authorization is required.	*Prior Authorization is required.*
Diabetes Treatment		
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. Benefits for diabetes supplies will be the same as those stated in the Outpatient Prescription Drug Rider.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Mastectomy Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Mental Health Services		
	Inpatient: 100% after Deductible has been met. Outpatient: 100% Deductible does not apply.	Inpatient: 50% after Deductible has been met. Outpatient: 50% after Deductible has been met. *Prior Authorization is required for certain services.*

Types of Coverage	Network Benefits	Non-Network Benefits
Off-Label Drug Use and Experimental or Investigational Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Osteoporosis Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Phenylketonuria (PKU) Treatment		
	100% after Deductible has been met.	50% after Deductible has been met. *Prior Authorization is required.*
Prosthetic Devices - Laryngectomy		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Prior Authorization is required as described in your Schedule of Benefits.*	*Prior Authorization is required as described in your Schedule of Benefits.*
Substance Use Disorder Services		
	Inpatient: 100% after Deductible has been met. Outpatient: 100% Deductible does not apply.	Inpatient: 50% after Deductible has been met. Outpatient: 50% after Deductible has been met. *Prior Authorization is required for certain services.*
Telehealth Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Temporomandibular Joint Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Prior Authorization is required for Inpatient Stay.*

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.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to general anesthesia and associated Hospital or Alternate Facility charges for which Benefits are provided as described under Dental Anesthesia Services in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of an acute traumatic health condition, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth. This exclusion does not apply to dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC and speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drugs products for use outside of a healthcare setting that are filled by a prescription order or refill (i.e. a supply of prescription drug products for home/personal use). This exclusion does not apply if the Policy includes an Outpatient Prescription Drug Rider. Self-injectable medications, except those needed to treat diabetes. This exclusion does not apply to medications which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under Section 9: Defined Terms and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the American Hospital Formulary Service's Drug Information; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Shoe orthotics. This exclusion does not apply to shoes for which Benefits are provided as described under Specialized Footwear in Section 1 of the COC. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Arch supports. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC.
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified as mental disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the final two chapters of Part II of the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. These codes are ICD-10-CM diagnostic and statistical codes beginning with the letter R or letter T. Educational/behavioral services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness or Serious Emotional Disturbances in Section 9 of the COC. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition, except as described under Phenylketonuria (PKU) Treatment in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods), except as described under Phenylketonuria (PKU) Treatment in Section 1 of the COC.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement and as required by California regulation); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Treatment of benign gynecomastia (abnormal breast enlargement in males). This exclusion does not apply to the reconstructive and Medically Necessary treatment of benign gynecomastia for male patients. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Psychosurgery. Gender/sex reassignment surgery is not covered unless the same procedure is allowed in the treatment of another condition, not related to gender identity or gender dysphoria. This exclusion does not permit the denial of coverage if the health care services involved are otherwise available under the Policy, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training. Also, this exclusion does not permit the denial of coverage for health care services available to a Covered Person of one sex due only to the fact that the Covered Person is enrolled as belonging to the other sex or has undergone, or is the process of undergoing, a gender transition. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations; and physical therapy modalities that have general value but show limited or no efficacy in the treatment of TMJ including cold laser, diathermy, thermography, iontophoresis, biofeedback, and TENS. Upper and lower jawbone surgery except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in Temporomandibular Joint (TMJ) Services under Section 1 of the COC. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under Other Health Education Services for You in the section of the COC titled Our Responsibilities. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under Preventive Care Services in Section 1of the COC. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion only applies when you are legally entitled to such other coverage and you are able to receive health services under the other coverage arrangement. Health services while on active military duty when you are on active duty for more than 30 days.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. The exclusion for methadone treatment as maintenance does not apply to Covered Persons during pregnancy and for two months after delivery received on an outpatient basis at a licensed treatment center. Educational/behavioral services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness and Serious Emotional Disturbances in Section 9 of the COC. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when the Covered Person has either of the following: Craniofacial anomalies in which normal or absent ear canals preclude the use of a wearable hearing aid, or Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following: Medically Necessary. Not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in the United States or non-war zones outside of the United States. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.