

Select Plus plan details, all in one place.

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

Check out what's included in the plan

Select Plus



Network coverage only

You can usually save money when you receive care for covered health care services from network providers.



Network and out-of-network benefits

You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.



Primary care physician (PCP) required

With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.



Referrals required

You'll need referrals from your PCP before seeing a specialist or getting certain health care services.



Preventive care covered at 100%

There is no additional cost to you for seeing a network provider for preventive care.



Pharmacy benefits

With this plan, you have coverage that helps pay for prescription drugs and medications.



Tier 1 providers

Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.



Freestanding centers

You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.



Health savings account (HSA)

With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.



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

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

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$2,550	\$5,100
Family	\$5,100	\$10,200
Ped Dental Annual Deductible - Family	Included in your medical deductible	Included in your medical deductible
Ped Dental Annual Deductible - Individual	Included in your medical deductible	Included in your medical deductible

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

**After the Annual Medical Deductible has been met.*

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

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	\$9,200	\$18,400
Family	\$18,400	\$36,800

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.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

	Network	Out-of-Network
Copays (\$) and Coinsurance (%) for Covered Health Care Services		
Preventive Care Services	No copay	Not covered

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 copay, co-insurance or deductible.

Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.

Office Services - Sickness & Injury		
Primary Care Physician	\$60 copay	50%*
Specialist	\$95 copay	50%*
Urgent Care Center Services	\$80 copay	50%*
Virtual Care Services	No copay	Not covered
<i>Benefits are available only when services are delivered through a Designated Virtual Network Provider for 24/7 Virtual Visit services only. You can find a 24/7 Virtual Visit Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to 24/7 Virtual Visits and prescription services may not be available in all states or for all groups.</i>		

**After the Annual Medical Deductible has been met.*

1Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Vision Exams (Benefit is for Covered Persons over age 19)

Limited to 1 exam per year.

Find a listing of UnitedHealthcare Vision Network Providers at myuhcvision.com.

Network	Out-of-Network
---------	----------------

\$30 copay

50%*

Emergency Care

Ambulance Services - Emergency Ambulance

Air Ambulance

40%*

40%*

Ground Ambulance

40%*

40%*

Ambulance Services - Non-Emergency Ambulance¹

Air Ambulance

40%*

40%*

Ground Ambulance

40%*

50%*

Dental Services - Accident Only

40%*

40%*

Emergency Health Care Services - Outpatient¹

You pay a \$300 per occurrence copay per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 40%*

You pay a \$300 per occurrence copay per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 40%*

Notification is required if it results in confinement to an Out-of-Network Hospital.

Inpatient Care

Congenital Heart Disease (CHD) Surgeries

You pay a \$250 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 40%*

Not covered

Habilitative Services - Inpatient¹

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

Hospital - Inpatient Stay¹

You pay a \$250 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 40%*

You pay a \$250 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services¹

40%*

50%*

Limited to 100 days per year in a Skilled Nursing Facility.

Outpatient Care

Acupuncture Services

\$60 copay

Not covered

Habilitative Services - Outpatient

\$60 copay

50%*

Limited to 24 visits of manipulative treatments per year.

Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatment.

Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Home Health Care ¹	40%*	50%*
<i>Limited to 100 visits per year.</i>		
<i>Out of Network: Limited to \$150 per visit for Allowed Amounts.</i>		
<i>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.</i>		
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing		
For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office	40%*	Not covered
For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center	50%*	Not covered
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing ¹		
For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office	40%*	50%*
For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center	50%*	50%*
Major Diagnostic and Imaging - Outpatient ¹		
For services provided at a freestanding diagnostic center or in a physician's office	40%*	50%*
For services provided at an outpatient hospital-based diagnostic center	50%*	50%*
<i>You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.</i>		
Physician Fees for Surgical and Medical Services	40%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	\$60 copay	50%*
<i>Limited to 24 visits of manipulative treatments per year.</i>		
<i>Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatment.</i>		
<i>Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.</i>		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
For services provided at a freestanding center or in a physician's office	40%*	50%*
For services provided at an outpatient hospital-based center	50%*	50%*
<i>Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.</i>		

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Surgery - Outpatient¹

For services provided at an ambulatory surgical center or in a physician's office

40%*

50%*

For services provided at an outpatient hospital-based surgical center

50%*

50%*

Out of Network: Limited to \$760 per date of service for Allowed Amount of Facility Fees.

There is no cost for network vasectomy services or procedures.

Therapeutic Treatments - Outpatient¹

40%*

50%*

Out-of-Network Benefits are not available for dialysis services.

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

Supplies and Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care¹

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

Durable Medical Equipment (DME), Orthotics and Supplies

40%*

Not covered

Enteral Nutrition

40%*

50%*

Hearing Aids

40%*

50%*

Limited to \$2,500 per year.

Limited to a single purchase per hearing impaired ear every 3 years.

Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.

Ostomy Supplies

40%*

Not covered

Pharmaceutical Products - Outpatient

40%*

50%*

This includes medications given on an outpatient basis in a Hospital, Alternate Facility or at a doctor's office.

Prosthetic Devices¹

40%*

50%*

Urinary Catheters

40%*

Not covered

¹After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Pregnancy

Pregnancy - Maternity Services¹

All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care act, will be provided without cost share. Please refer to Preventive Care Services.

Benefits for office visits for prenatal care received from a Network provider are covered without cost sharing during the entire course of the pregnancy.

There is no cost for the first postnatal/postpartum visit.

We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.

Mental Health Care & Substance Related and Addictive Disorder Services

Inpatient ¹	40%*	50%*
Intensive Behavioral Therapy (e.g. ABA) ¹	20%	50%*
Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation and Medication Assisted Treatment ¹	20%	50%*
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs ¹	40%*	50%*
Outpatient Office Visits	\$60 copay	50%*

There is no cost for school site outpatient Mental Health Care and Substance-Related and Addictive Disorders Services.

Other Services

Abortion and Abortion Related Services	No copay	No copay
Cellular and Gene Therapy	The amount you pay is based on where the covered health care service is provided.	Not covered
Clinical Trials ¹	The amount you pay is based on where the covered health care service is provided.	
Dental Anesthesia Services	40%*	50%*
<i>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.</i>		
Diabetes Treatment	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 Prescription Drug Benefits Section.	
<i>Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.</i>		

¹After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Fertility Preservation for Iatrogenic Infertility ¹	40%*	50%*
Gender Dysphoria	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
<i>Limits for voice modification therapy and/or voice lessons will be the same as, and combined with, outpatient speech therapy limits as described under Habilitative Services and Rehabilitation Services Outpatient Therapy and Manipulative Treatment.</i>		
Home Test Kits for Sexually Transmitted Diseases	The amount you pay is based on where the covered health care service is provided.	
Hospice Care ¹	40%*	50%*
Mastectomy Services	The amount you pay is based on where the covered health care service is provided.	
Obesity - Weight Loss Surgery ¹	The amount you pay is based on where the covered health care service is provided.	Not covered
<i>Obesity - weight loss surgery must be received from a Designated Provider.</i>		
Off-Label Drug Use and Experimental or Investigational Services	The amount you pay is based on where the covered health care service is provided.	
Osteoporosis Services	The amount you pay is based on where the covered health care service is provided.	
Preimplantation Genetic Testing (PGT) and Related Services ¹	40%*	50%*
Reconstructive Procedures ¹	The amount you pay is based on where the covered health care service is provided.	
Specialized Footwear	40%*	50%*
Telehealth Services	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services ¹	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services	The amount you pay is based on where the covered health care service is provided.	Not covered

For Network Benefits, transplantation services must be received from a Designated Provider.

Pediatric Services - Dental

All Pediatric Dental - Benefits covered up to age 19		
<i>Additional limits may apply. Refer to your plan documents for more information.</i>		
Basic Dental Services	20%*	50%*
Diagnostic Services	No copay	50%*
<i>Limited to 1 evaluation (checkup exam) every 6 months.</i>		
<i>Limited to 1 series of films every 6 months of Bitewing x-rays.</i>		
<i>Limited to 1 time every 36 months for Panoramic x-rays.</i>		
Major Restorative Services	50%*	50%*

¹After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Medically Necessary Orthodontics¹

50%*

Out-of-Network

50%*

All orthodontic treatment must be prior authorized.

Preventive Services

No copay

50%*

Limited to 1 dental prophylaxis cleaning and fluoride treatment every 6 months.

Pediatric Services - Vision

All Pediatric Vision - Benefits Covered up to age 19

Contact Lenses/Necessary Contact Lenses

40%

50%

Limited to 1 fitting and evaluation every 12 months.

Limited to a 12 month supply.

We will pay benefits for only one vision care service. You may choose either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses.

Eyeglass Frames

Eyeglass frames with a retail cost below \$130

40%

50%

Eyeglass frames with a retail cost between \$130-\$160

40%

50%

Eyeglass frames with a retail cost between \$160-\$200

40%

50%

Eyeglass frames with a retail cost between \$200-\$250

40%

50%

Eyeglass frames with a retail cost greater than \$250

40%

50%

Limited to once every 12 months.

Eyeglass Lenses

40%

50%

Limited to once every 12 months.

Lens Extras

No copay

No copay

Limited to once every 12 months.

Coverage includes polycarbonate lenses and standard scratch-resistant coating.

Low Vision Follow-up Care

No copay

25%

Limited to 4 visits every 5 years.

Low Vision Testing

No copay

25%

Limited to once every 24 months.

Low Vision Therapy

25%

25%

Limited to once every 24 months.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Low vision aid such as high-power spectacles, magnifiers and telescopes

Limited to once per year.

Routine Vision Exam

25%

Network

Out-of-Network

25%

Limited to once every 12 months.

Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details			
Pharmacy Network		National	
Prescription Drug List		Custom Advantage (state mandated) w/ SMCS Drugs	
In Network			
Annual Pharmacy Deductible			
Individual	\$350		
Family	\$700		
<p>*After the Annual Pharmacy Deductible has been met.</p> <p>Annual Pharmacy Deductible - Network and Out-of-Network</p> <p>Out-of-network benefits are not available for your pharmacy coverage.</p> <p>The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.</p>			
Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	Retail Non-preferred Specialty Network Pharmacy	In-Network Mail Order Pharmacy**
Tier 1 \$	\$20	Not applicable	\$50
Tier 2 \$\$	\$85*	Not applicable	\$212.50*
Tier 3 \$\$\$	\$135*	Not applicable	\$337.50*
Tier 4 \$\$\$\$	25% however you will not pay more than \$250*	Not applicable	25% however you will not pay more than \$625*
Specialty Prescription Drug Product Tier Level	In-Network Specialty Pharmacy	Retail Non-preferred Specialty Network Pharmacy	Specialty Mail Order**
Tier 1 \$	\$20	\$20	Not applicable
Tier 2 \$\$	\$150*	\$150*	Not applicable
Tier 3 \$\$\$	\$250*	\$250*	Not applicable
Tier 4 \$\$\$\$	25% however you will not pay more than \$250*	25% however you will not pay more than \$250*	Not applicable

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

Your Copayment and/or Coinsurance 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, Tier 3 or Tier 4.

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

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, \$15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.



Search the network to find doctors.

You can go to providers in and out of our network—but when you stay in network, you'll likely pay less for care. To get started:

- Go to welcometouhc.com > Benefits > Find a Doctor or Facility.
- Choose **Search for a health plan**.
- Choose **Select Plus** to view providers in the health plan's network.



Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to welcometouhc.com > Benefits > Pharmacy Benefits.
- Select **Advantage** to view the medications that are covered under your plan.



Access your plan online.

With myuhc.com®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Good stuff
that's good
to know.

I dig it!

Other important information about your benefits.

Medical Exclusions

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

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

Outpatient Prescription Drug Benefits

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

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

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

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

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

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

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

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

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order 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 an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

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

- A Pharmaceutical Product for which Benefits are provided in your Combined Evidence of Coverage and Disclosure Form.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government except as otherwise provided by law.
- Any product dispensed for the purpose of appetite suppression or weight loss. This exclusion does not exclude coverage for drugs when Prior Authorized as Medically Necessary to treat morbid obesity.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation unless they are FDA-approved tobacco cessation drugs and products.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives to another Prescription Drug Product or Pharmaceutical Product as described in your Certificate available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision to an over-the-counter drug or supplement.
- Certain compounded drugs unless Prior Authorized as Medically Necessary by UnitedHealthcare.
- Drugs available over-the-counter unless Medically Necessary. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay in a hospital or Skilled Nursing Facility.
- Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Combined Evidence of Coverage and Disclosure Form. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition) unless Medically Necessary and Prior Authorized by us.
- Medications used for cosmetic or convenience purposes.
- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Combined Evidence of Coverage and Disclosure Form.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.

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

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

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

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

Complaint forms are available at:

<http://www.hhs.gov/ocr/office/file/index.html>.

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

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

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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

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

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

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

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

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

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

فُوغللَ اَدْعَاسِمْلَا تَامِدْخَنَافْ، **هِيَرْعَلَا ثَدْحَتْ تَنْكَ اَذَا مِيَبَنْتَ**
عَلَعْ جَرْدَلَا يَنْاجَمَلَا فَتَأْمَلَا مَقْرَبْ لَاصِنَتَالَا ىَجْرُيْ لَكْلَ ٰحَاتَمْ هِيَنْاجَمَلَا
كَبْ قَصَّاخَلَا فَيَرْعَلَلَا قَقَاطَبْ

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisyé 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. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिन्दी (**Hindi**) बोलते हैं, आपको भाषा सहायता सुनाएं, नाशुल्क उपलब्ध है। कपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर काल करें।

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

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

PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahé 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 yáñílti'go, saad bee áka'anída'awo'íigíi, t'áá jiík'eh, bee ná'ahóót'i'. T'áá shqodí ninaaltoos nitl'ízí bee nééhoziníigíi bine'déé' t'áá jiík'ehgo béésh bee hane'í biká'íigíi bee hodíilnih.

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

ગુજરાતી (Gujarati**):** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિભાગ મૂલ્ય પરાપર્ય છે. મહેરબાની કરી તમારા આઈડી કાડડની સૂચિપિર આપેલા સેવાએ માટેના ટોલ-ફૂરી નંબર ઉપર કોલ કરો.