# 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**<br>You can usually save money when you receive care for covered health care services from network providers. | ☐ |
| **Network and out-of-network benefits**<br>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**<br>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**<br>You'll need referrals from your PCP before seeing a specialist or getting certain health care services. | ☐ |
| **Preventive care covered at 100%**<br>There is no additional cost to you for seeing a network provider for preventive care. | ☑ |
| **Pharmacy benefits**<br>With this plan, you have coverage that helps pay for prescription drugs and medications. | ☑ |
| **Tier 1 providers**<br>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**<br>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)**<br>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 | $250 | $250 |
| Family | $750 | $750 |

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

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

*Any amount you pay for Covered Health Care Services applied to the Network Annual Deductible will be applied to the Out-of-Network Annual Deductible. Any amount you pay for Covered Health Care Services applied to the Out-of-Network Annual Deductible will be applied to the Network Annual Deductible.*

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

| | | |
|---|---|---|
| **Annual Out-of-Pocket Limit** | | |
| Individual | $2,250 | $6,500 |
| Family | $4,500 | $13,000 |

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

*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 | |
|---|---|---|
| **Copays ($) and Coinsurance (%) for Covered Health Care Services** | **Network** | **Out-of-Network** |
| **Preventive Care Services** | | |
| Preventive Care Services<br><br>*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.*<br><br>*Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.* | No copay | Not covered |

*After the Annual Medical Deductible has been met.

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

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | Network | Out-of-Network |
| **Office Services - Sickness & Injury** | | |
| Primary Care Physician<br><br>*Telehealth is covered at the same cost share as in the office.* | $20 copay | 30%* |
| Specialist<br><br>*Telehealth is covered at the same cost share as in the office.* | $20 copay | 30%* |
| Urgent Care Center Services | $20 copay | 30%* |
| Virtual Care Services<br><br>*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.* | No copay | Not covered |
| Vision Exams<br><br>*Limited to 1 exam every 24 months.*<br><br>*Find a listing of UnitedHealthcare Vision Network Providers at myuhcvision.com.* | $20 copay | Not covered |
| **Emergency Care** | | |
| Ambulance Services - Emergency Ambulance | | |
| Air Ambulance | 10%* | 10%* |
| Ground Ambulance | 10%* | 10%* |
| Ambulance Services - Non-Emergency Ambulance[1] | | |
| Air Ambulance | 10%* | 10%* |
| Ground Ambulance | 10%* | 10%* |
| Dental Services - Accident Only | 10%* | 10%* |
| Emergency Services and Care - Outpatient<br><br>*Notification is required if it results in confinement to an Out-of-Network Hospital.* | $150 copay, then 10% | $150 copay, then 10% |
| **Inpatient Care** | | |
| Congenital Heart Disease (CHD) Surgeries[1] | 10%* | 30%* |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | **Network** | **Out-of-Network** |
| Habilitative Services - Inpatient[1]<br><br>*Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.* | The amount you pay is based on where the covered health care service is provided. | |
| Hospital - Inpatient Stay[1] | 10%* | 30%* |
| Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1]<br><br>*Limited to 100 days per year in a Skilled Nursing Facility.* | 10%* | 30%* |
| **Outpatient Care** | | |
| Habilitative Services - Outpatient<br><br>*Limits will be the same as, and combined with, those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*<br><br>*Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatment.*<br><br>*Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including Autism Spectrum Disorders.* | $20 copay | 30%* |
| Home Health Care[1]<br><br>*Limited to 100 visits per year.*<br><br>*Out of Network: Limited to $150 per visit for Allowed Amounts.*<br><br>*One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.* | 10%* | 30%* |
| Lab, X-Ray and Diagnostic - Outpatient - Lab Testing | | |
| For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office | No copay | Not covered |
| For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center | 10% | Not covered |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | **Network** | **Out-of-Network** |
| 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 | 10% | 30%* |
| For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center | 10% | 30%* |
| *For network benefits you have no copay for a diagnostic mammogram or breast ultrasound for the first service in a year.* | | |
| Major Diagnostic and Imaging - Outpatient[1] | | |
| For services provided at a freestanding diagnostic center or in a physician's office | 10%* | 30%* |
| For services provided at an outpatient hospital-based diagnostic center | 10%* | 30%* |
| *For network benefits you have no copay for a breast MRI for the first service in a year.* | | |
| *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.* | | |
| Physician Fees for Surgical and Medical Services | 10%* | 30%* |
| Rehabilitation Services - Outpatient Therapy and Manipulative Treatment | $20 copay | 30%* |
| *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 Autism Spectrum Disorders.* | | |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | Network | Out-of-Network |
| Scopic Procedures - Outpatient Diagnostic and Therapeutic | | |
| For services provided at a freestanding center or in a physician's office | 10%* | 30%* |
| For services provided at an outpatient hospital-based center | 10%* | 30%* |
| *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.* | | |
| *For network benefits you have no copay for a diagnostic colonoscopy for the first service in a year.* | | |
| Surgery - Outpatient[1] | | |
| For services provided at an ambulatory surgical center or in a physician's office | $150 copay, then 10% | 30%* |
| For services provided at an outpatient hospital-based surgical center | 10%* | 30%* |
| *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 - Outpatient[1] | 10%* | 30%* |
| *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 Items[1] | 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. | |
| Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1] | The amount you pay is based on where the covered health care service is provided. | |
| *For self-management and training, cost sharing will not exceed the costs for Physician office visits.* | | |
| Durable Medical Equipment (DME), Orthotics and Supplies | 10%* | Not covered |
| Enteral Nutrition | 10%* | 30%* |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | Network | Out-of-Network |
| Hearing Aids<br><br>*Limited to $2,500 per year.*<br><br>*Limited to a single purchase per hearing impaired ear every 3 years.*<br><br>*Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.* | 10%* | 30%* |
| Ostomy Supplies | 10%* | Not covered |
| Pharmaceutical Products - Outpatient<br><br>*This includes medications given on an outpatient basis in a Hospital, Alternate Facility, doctor's office, or in a covered person's home.* | 10%* | 30%* |
| Prosthetic Devices[1]<br><br>*Limited to a single purchase of each type of prosthetic device every 3 years.*<br><br>*Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.* | 10%* | 30%* |
| Urinary Catheters | 10%* | Not covered |
| **Pregnancy** | | |
| Pregnancy - Maternity Services[1]<br><br>*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.*<br><br>*We pay for Covered Benefits incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.* | The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. | |
| **Mental Health Care & Substance Related and Addictive Disorder Services** | | |
| Inpatient[1] | 10%* | 30%* |
| Intensive Behavioral Therapy (e.g. ABA)[1] | 10% | 30%* |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | **Network** | **Out-of-Network** |
| Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation and Medication Assisted Treatment[1] | 10% | 30%* |
| Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs[1] | 10%* | 30%* |
| Outpatient Office Visits<br><br>*There is no cost for school site outpatient Mental Health or Substance Use Disorder Services.* | $20 copay | 30%* |
| **Other Services** | | |
| Abortion and Abortion Related Services | No copay | No copay |
| Acupuncture Services<br><br>*Limited to 20 treatments per year.* | $20 copay | Not covered |
| Biomarker Testing | The amount you pay is based on where the covered health care service is provided. | |
| Cellular and Gene Therapy<br><br>*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. | Not covered |
| Clinical Trials[1] | The amount you pay is based on where the covered health care service is provided. | |
| Dental Anesthesia Services[1]<br><br>*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.* | 10%* | 30%* |
| Emergency Medical Services Provided by a Community Paramedicine Program, a Triage to Alternate Destination Program, and a Mobile Integrated Health Program | The amount you pay is based on where the covered health care service is provided. | |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | Network | Out-of-Network |
| Emergency Room Medical Care and Follow-up Health Care Treatment for Rape and Sexual Assault | | |
| All visits for the first nine months after treatment is initiated | No copay | 30%* |
| Subsequent visits after nine months treatment is initiated | 10%* | 30%* |
| *There is no cost for emergency room medical care and follow-up health care treatment for a Covered Person who is treated following a rape or sexual assault for the first nine months after treatment is initiated.* | | |
| Gender Dysphoria | The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section. | |
| *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.* | | |
| Home Test Kits for Sexually Transmitted Diseases | No copay | 30%* |
| Hospice Care[1] | 10%* | 30%* |
| Human Milk | 10%* | 30%* |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | **Network** | **Out-of-Network** |
| Infertility Services[1] | | |
| Hospital - Inpatient Stay | 10%* | 30%* |
| Lab Testing - Outpatient: For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office | No copay | Not covered |
| Lab Testing - Outpatient: For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center | 10% | Not covered |
| Physician Fees for Surgical and Medical Services | 10%* | 30%* |
| Physician's Office Services - Primary Care Physician | $20 copay | 30%* |
| Physician's Office Services - Specialist | $20 copay | 30%* |
| Surgery - Outpatient: For services provided at an ambulatory surgical center or in a physician's office | $150 copay, then 10% | 30%* |
| Surgery - Outpatient: For services provided at an outpatient hospital-based surgical center | 10%* | 30%* |
| X-Ray and other Diagnostic Testing - Outpatient: For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office | 10% | 30%* |
| X-Ray and other Diagnostic Testing - Outpatient: For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center | 10% | 30%* |
| *Limited to 5 years per lifetime for cryopreservation and storage of sperm, oocytes, and embryos from the time the genetic material is first cryopreserved.* | | |
| *Limited to a maximum of 3 oocyte retrievals per lifetime.* | | |
| *Limit includes unlimited embryo transfers.* | | |
| *Primary Care Physician telehealth is covered at the same cost share as in the office.* | | |
| *Specialist telehealth is covered at the same cost share as in the office.* | | |
| Mastectomy Services[1] | 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 |
| *Obesity - weight loss surgery must be received from a Designated Provider.* | | |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | Network | Out-of-Network |
| 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. | |
| Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) | The amount you pay is based on where the covered health care service is provided. | |
| Preimplantation Genetic Testing (PGT) and Related Services[1]<br><br>*Benefit limits for related services will be the same as those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.* | 10%* | 30%* |
| Reconstructive Procedures[1] | The amount you pay is based on where the covered health care service is provided. | |
| Standard Fertility Preservation Services for Iatrogenic Infertility[1]<br><br>*Limited to 2 attempts of embryo creation per lifetime.*<br><br>*Limited to 2 attempts to collect sperm for members with testicles per lifetime.*<br><br>*Limited to 2 attempts to retrieve gonadal tissue per lifetime.*<br><br>*Limited to 2 cycles for oocyte retrieval for members with ovaries per lifetime.* | 10%* | 30%* |
| 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<br><br>*For Network Benefits, transplantation services must be received from a Designated Provider.* | The amount you pay is based on where the covered health care service is provided. | Not covered |

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

# Pharmacy Benefits

| Pharmacy Plan Details | |
|---|---|
| Pharmacy Network | National |
| Prescription Drug List | Access |

| | In Network and Out of Network |
|---|---|
| **Annual Pharmacy Deductible** | |
| Individual | You do not have to pay a pharmacy deductible |
| Family | You do not have to pay a pharmacy deductible |

| | In Network and Out of Network |
|---|---|
| **Annual Pharmacy Out-of-Pocket Limit** | |
| Individual | See the Annual Medical Out-of-Pocket Section |
| Family | See the Annual Medical Out-of-Pocket Section |

| Prescription Drug Product Tier Level | Up to a 31-day supply | | Up to a 90-day supply |
|---|---|---|---|
| | In-Network Retail Pharmacy | Out-of-Network Retail Pharmacy | In-Network Mail Order Pharmacy** |
| Tier 1 $ | $5 | $5 | $10 |
| Tier 2 $$ | $25 | $25 | $50 |
| Tier 3 $$$ | $40 | $40 | $80 |
| Tier 4 $$$$ | $45 | $45 | $90 |

* After the Annual Pharmacy Deductible has been met.

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

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.

For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

# 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.

## Digital tools to keep you connected

Once you're a member, you can access your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – these tools give you quick access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Quickly compare cost estimates before you get care, which may help you save money

### Get connected

**Scan this code to download the UnitedHealthcare app or visit myuhc.com**

# 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/Child)
- Glasses
- 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 Evidence of Coverage.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in your Evidence of Coverage.
- Any product dispensed for the purpose of appetite suppression or weight loss. This exclusion does not apply to outpatient Prescription Drug Products prescribed and prior authorized for the Medically Necessary treatment of morbid obesity.
- 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 which there are Therapeutically Equivalent alternatives to another Prescription Drug Product or Pharmaceutical Product as described in your Evidence of Coverage 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.
- Certain compounded drugs.
- Drugs or products available over-the-counter. This exclusion does not apply to FDA-approved contraceptive drugs, devices, other products including all FDA-approved contraceptive drugs, devices, and products available over-the-counter and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1: Covered Health Care Services. This also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or 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: Covered Health Care Services.
- Experimental or Investigational or Unproven Services and medications. This exclusion does not apply to Prescription Drug Products described under Off-Label Drug Use and Experimental or Investigational Services in Section 1 of the Evidence of Coverage.
- Prescription Drug Products used for cosmetic or convenience purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service, unless medically necessary.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

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

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

**Online: UHC_Civil_Rights@uhc.com**

**Mail:** Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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