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		
Single Coverage	$4,000	$7,000
Family Coverage	$7,900	$14,000

No one in the family is eligible for benefits until the family coverage deductible is 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.

Annual Out-of-Pocket Limit		
Individual	$6,750	$15,700
Family	$13,500	$31,400

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 *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.* *The IRS minimum Annual Deductible applies for supplemental breast exams and diagnostic breast exams.*	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		
For the first 3 visits in a year	$5 copay*	40%*
Subsequent visits in a year	20%*	40%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work. *Applies to physician office visits for medical and outpatient mental health/substance abuse services provided by a PCP.* *Benefits for the first 3 visits are combined with the Benefits under Autism Spectrum Disorder Services - Behavioral, Mental Health Care & Substance Related and Addictive Disorder Services and Physician's Office Services - Sickness and Injury in this Benefit Summary. Visits are not combined with the Benefits under Preventive Care Services.* *Benefits under this category include services performed by a Naturopathic Physician.* *Telemedical Services are covered at the same cost share as in the office.*		
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Benefits under this category include services performed by a Naturopathic Physician.* *Telemedical Services are covered at the same cost share as in the office.*	20%*	40%*
Urgent Care Center Services	20%*	40%*
Emergency Care		
Ambulance Services - Emergency Ambulance		
Air Ambulance	20%*	20%*
Ground Ambulance	20%*	20%*

*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
Ambulance Services - Non-Emergency Ambulance[1]		
Air Ambulance	20%*	20%*
Ground Ambulance	20%*	20%*
Dental Services - Accident Only	20%*	20%*
Emergency Health Care Services - Outpatient[1] *Notification is required if it results in confinement to an Out-of-Network Hospital.*	20%*	20%*
Inpatient Care		
Congenital Heart Disease (CHD) Surgeries[1]	20%*	40%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.* *These visit limits are subject to medical necessity and will not apply to Autism Spectrum Disorder Services - Behavioral Services or Mental Health Care and Substance-Related and Addictive Disorders Services.*	The amount you pay is based on where the covered health care service is provided.	
Hospital - Inpatient Stay[1]	20%*	40%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year in a Skilled Nursing Facility/Inpatient Rehabilitation Facility.*	20%*	40%*
Outpatient Care		
Acupuncture Services *Limited to 12 treatments per year.*	20%*	20%*
Habilitative Services - Outpatient *Limits will be the same as, and combined with, those stated under Rehabilitation Services - Outpatient Therapy.* *These visit limits are subject to medical necessity and will not apply to Autism Spectrum Disorder Services - Behavioral Services or Mental Health Care and Substance-Related and Addictive Disorders Services.*	20%*	40%*

*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
Home Health Care[1] *Limited to 130 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	20%*	40%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing	20%*	Not covered
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]	20%*	40%*
Major Diagnostic and Imaging - Outpatient[1] *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	20%*	40%*
Physician Fees for Surgical and Medical Services	20%*	40%*
Rehabilitation Services - Outpatient Therapy *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 30 visits per year for severe neurologic conditions.* *Limited to 36 visits of cardiac rehabilitation therapy per year.* *These visit limits are subject to medical necessity and will not apply to Autism Spectrum Disorder Services-Behavioral Services or Mental Health Care and Substance-Related and Addictive Disorders Services.*	20%*	40%*

*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 *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 after the deductible has been met for the first service in a year.*	20%*	40%*
Surgery - Outpatient[1]	20%*	40%*
Therapeutic Treatments - Outpatient[1] *Out-of-Network Benefits are not covered for dialysis services.* *Therapeutic treatments include, but are not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*	20%*	40%*
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.	
Durable Medical Equipment (DME), Orthotics and Supplies *Limited to a single purchase of a type of DME every 3 years.* *Limits do not apply to orthotics covered under DME.* *Repair and/or replacement of DME would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*	20%*	Not covered
Enteral Nutrition	20%*	40%*

*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 *Limited to a single purchase per hearing impaired ear every 3 years.* *Ear molds and replacement ear molds are limited at least 4 times per plan year for Covered Persons younger than 8 years of age and once per year for Covered Persons ages 8 through 25 years. Coverage includes one box of replacement batteries per year for each hearing aid.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.* *The purchase may be more frequent if modifications to an existing hearing aid will not meet the needs of a Covered Person.*	20%*	40%*
Ostomy Supplies	20%*	Not covered
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*	20%*	40%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every 3 years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*	20%*	40%*
Urinary Catheters	20%*	Not covered
Pregnancy		
Pregnancy - Maternity Services[1] *Benefits for Medically Necessary treatments for a woman to manage her maternal diabetes from conception through six weeks post-partum is not subject to co-payments, co-insurance or annual deductibles. This applies to both Network and Out-of-Network services.*	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient[1]	20%*	40%*
Intensive Behavioral Therapy (e.g. ABA)[1]	20%*	40%*

*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]	20%*	40%*
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs[1]	20%*	40%*
Outpatient Office Visits		
For the first 3 visits in a year	$5 copay*	40%*
Subsequent visits in a year	20%*	40%*
Applies to physician office visits for medical and outpatient mental health/substance abuse services provided by a PCP. *Benefits for the first 3 visits are combined with the Benefits under Autism Spectrum Disorder Services - Behavioral, Mental Health Care & Substance Related and Addictive Disorder Services and Physician's Office Services - Sickness and Injury in this Benefit Summary. Visits are not combined with the Benefits under Preventive Care Services.*		
Other Services		
Autism Spectrum Disorder - Medical Services[1] *Limited to 20 visits of occupational therapy.* *Limited to 20 visits of physical therapy.* *Limited to 20 visits of speech therapy.* *An additional 30 visits for severe neurologic conditions may be available when Medically Necessary. These visit limits are subject to medical necessity and will not apply to Autism Spectrum Disorder Services - Behavioral Services or Mental Health Care and Substance-Related and Addictive Disorders Services.* *Treatment for Autism Spectrum Disorder - Medical Services is considered a mental health benefit. Such treatment encompasses problems associated with Autism Spectrum Disorder - Medical Services for which rehabilitative or habilitative services would be appropriate for Covered Persons.*	The amount you pay is based on where the covered health care service is provided.	
Autism Spectrum Disorder Services - Behavioral Services Inpatient[1]	20%*	40%*

*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
Autism Spectrum Disorder Services - Behavioral Services - Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs[1]	20%*	40%*
Autism Spectrum Disorder Services - Behavioral Services Intensive Behavioral Therapy (e.g. ABA)[1]	20%*	40%*
Autism Spectrum Disorder Services - Behavioral Services Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation and Medication Assisted Treatment[1]	20%*	40%*
Autism Spectrum Disorder Services - Behavioral Services Outpatient Office Visits		
For the first 3 visits in a year	$5 copay*	40%*
Subsequent visits in a year	20%*	40%*
Applies to physician office visits for medical and outpatient mental health/substance abuse services provided by a PCP. *Benefits for the first three visits are combined with the Benefits under Autism Spectrum Disorder Services - Behavioral, Mental Health Care & Substance Related and Addictive Disorder Services and Physician's Office Services - Sickness and Injury in this Benefit Summary.*		
Cellular and Gene Therapy *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	Not covered
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.	
Cochlear Implants[1]	The amount you pay is based on where the covered health care service is provided.	
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to 1 cycle of fertility preservation for Iatrogenic Infertility per lifetime.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services.*	20%*	40%*

*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
Gender Dysphoria (Gender Affirming Care)[1] *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.*	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hearing Assistive Listening Devices and Bone Conduction Sound Processors[1] *Limited to a single purchase every 3 years.* *Benefits are available for hearing assistive listening devices for a Covered Person who is younger than 19 years of age, if necessary for appropriate amplification of hearing loss.*	20%	50%
Hearing Loss Diagnostic and Treatment Services[1] *Benefits are available for necessary diagnostic and treatment services at least twice a year for Covered Persons who are younger than four years of age and at least once per year for Covered Persons who are four years of age or older.*	The amount you pay is based on where the covered health care service is provided.	
Hospice Care[1]	20%*	40%*
Oregon Universal Newborn Nurse Home Visiting Program[1] *Benefits available for dependent newborns up to the age of six months, and at least one visit during a newborn's first three months of life with the opportunity for three additional visits.*	No copay*	40%*
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.*	20%*	40%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.	
Spinal Manipulative Treatment Services *Limited to 20 visits of manipulative treatments per year.*	20%*	20%*

*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**
Telemedical Services		
On Demand National Providers	No copay*	The amount you pay is based on where the covered health care service is provided.
Other Network Providers	The amount you pay is based on where the covered health care service is provided.	
Tobacco Use Cessation	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services *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
Voluntary Sterilization Procedures and Termination of Pregnancy[1]	No copay*	40%*

*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	Advantage
	In Network and Out of Network
Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section

Annual Deductible - Network and Out-of-Network

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

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 $	$15*	$15*	$37.50*
Tier 2 $$	$35*	$35*	$87.50*
Tier 3 $$$	$70*	$70*	$175*

* 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 or Tier 3.

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.

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

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 Certificate.
- 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 Certificate.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- 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 as required by state mandate. This exclusion does not apply to Benefits described under Enteral Nutrition in your Certificate.
- 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 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.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs or products available over-the-counter.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. 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. This exclusion does not apply to Prescription Drug Products which are prescribed for an indication not approved by the United States Food and Drug Administration if the Prescription Drug Product has been recognized by the Oregon Health Resources Commission as safe and effective for treatment of a particular indication.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition), except when deemed medically necessary and prescribed in accordance with accepted standards for gender affirming care.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency Medical Condition treatment.
- Prescription Drug Products for tobacco cessation, except those services on the "A" & "B" list of preventive services as recommended by the United States Preventive Services Task Force (USPSTF) for Tobacco Use and Cessation.
- Prescription Drug Products used for cosmetic or convenience purposes. This does not apply to medications medically necessary for gender-affirming care.
- 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 Certificate.
- 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.
- 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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