

# Choice 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                                               |                                                                                                                                                                                                                            | Choice Plus                         |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
|    | <b>Network coverage only</b><br>You can usually save money when you receive care for covered health care services from network providers.                                                                                  | <input type="checkbox"/>            |
|    | <b>Network and out-of-network benefits</b><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.                           | <input checked="" type="checkbox"/> |
|    | <b>Primary care physician (PCP) required</b><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.       | <input type="checkbox"/>            |
|   | <b>Referrals required</b><br>You'll need referrals from your PCP before seeing a specialist or getting certain health care services.                                                                                       | <input type="checkbox"/>            |
|  | <b>Preventive care covered at 100%</b><br>There is no additional cost to you for seeing a network provider for preventive care.                                                                                            | <input checked="" type="checkbox"/> |
|  | <b>Pharmacy benefits</b><br>With this plan, you have coverage that helps pay for prescription drugs and medications.                                                                                                       | <input checked="" type="checkbox"/> |
|  | <b>Tier 1 providers</b><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. | <input type="checkbox"/>            |
|  | <b>Freestanding centers</b><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.                    | <input checked="" type="checkbox"/> |
|  | <b>Health savings account (HSA)</b><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.                                     | <input type="checkbox"/>            |

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 Choice Plus works.

## Medical Benefits

|                                  | In Network | Out-of-Network |
|----------------------------------|------------|----------------|
| <b>Annual Medical Deductible</b> |            |                |
| Individual                       | \$2,000    | \$6,000        |
| Family                           | \$4,000    | \$12,000       |

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

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.

|                                   |          |          |
|-----------------------------------|----------|----------|
| <b>Annual Out-of-Pocket Limit</b> |          |          |
| Individual                        | \$5,000  | \$15,000 |
| Family                            | \$10,000 | \$30,000 |

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 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------|
| <b>Preventive Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |                |
| Preventive Care Services                                                                                                                                                                                                                                                                                                                                                                                                                                                        | No copay   | Not covered    |
| <p>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.</p> <p>Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.</p> |            |                |
| <b>Office Services - Sickness &amp; Injury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |            |                |
| Primary Care Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$30 copay | 50% *          |
| Telehealth is covered at the same cost share as in the office.                                                                                                                                                                                                                                                                                                                                                                                                                  |            |                |
| Specialist                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$60 copay | 50% *          |
| Telehealth is covered at the same cost share as in the office.                                                                                                                                                                                                                                                                                                                                                                                                                  |            |                |
| Urgent Care Center Services                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$50 copay | 50% *          |
| Virtual Care Services                                                                                                                                                                                                                                                                                                                                                                                                                                                           | No copay   | Not covered    |
| <p>Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.</p>                                                                                                                         |            |                |

\*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

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

Vision Exams

\$30 copay

Not covered

Limited to 1 exam every 24 months.

Find a listing of UnitedHealthcare Vision Network Providers at [myuhcvision.com](http://myuhcvision.com).

#### Emergency Care

Ambulance Services - Emergency Ambulance

Air Ambulance

20%\*

20%\*

Ground Ambulance

20%\*

20%\*

Ambulance Services - Non-Emergency Ambulance<sup>1</sup>

Air Ambulance

20%\*

20%\*

Ground Ambulance

20%\*

50%\*

Dental Services - Accident Only

20%\*

20%\*

Emergency Health Care Services - Outpatient

20%\*

20%\*

#### Inpatient Care

Congenital Heart Disease (CHD) Surgeries<sup>1</sup>

20%\*

50%\*

Habilitative Services - Inpatient<sup>1</sup>

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

Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.

Hospital - Inpatient Stay<sup>1</sup>

20%\*

50%\*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services<sup>1</sup>

20%\*

50%\*

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

#### Outpatient Care

Habilitative Services - Outpatient

\$30 copay

50%\*

Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.

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.

<sup>1</sup>Prior 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 <sup>1</sup>                                                                                                                                                                     | 20% *      | 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                                                                                            | 20% *      | 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 <sup>1</sup>                                                                                                          |            |                |
| For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office                                                                                            | 20% *      | 50% *          |
| For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center                                                                                                   | 20% *      | 50% *          |
| Major Diagnostic and Imaging - Outpatient <sup>1</sup>                                                                                                                                            |            |                |
| For services provided at a freestanding diagnostic center or in a physician's office                                                                                                              | 20% *      | 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                                                                                                                                                  | 20% *      | 50% *          |
| Rehabilitation Services - Outpatient Therapy and Manipulative Treatment                                                                                                                           | \$30 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 Autism Spectrum Disorders.</i> |            |                |
| Scopic Procedures - Outpatient Diagnostic and Therapeutic                                                                                                                                         |            |                |
| For services provided at a freestanding center or in a physician's office                                                                                                                         | 20% *      | 50% *          |
| For services provided at an outpatient hospital-based center                                                                                                                                      | 20% *      | 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.

<sup>1</sup>Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

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

| Network                                                                                                                                                                                      | Out-of-Network |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| 20% *                                                                                                                                                                                        | 50% *          |
| 20% *                                                                                                                                                                                        | 50% *          |
| 20% *                                                                                                                                                                                        | 50% *          |
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| 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. |                |
| The amount you pay is based on where the covered health care service is provided.                                                                                                            |                |
| 20% *                                                                                                                                                                                        | Not covered    |
| 20% *                                                                                                                                                                                        | 50% *          |
| 20% *                                                                                                                                                                                        | 50% *          |
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|                                                                                                                                                                                              |                |
| 20% *                                                                                                                                                                                        | Not covered    |
| 20% *                                                                                                                                                                                        | 50% *          |
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| 20% *                                                                                                                                                                                        | 50% *          |
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| 20% *                                                                                                                                                                                        | Not covered    |

\*After the Annual Medical Deductible has been met.

<sup>1</sup>Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

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

| Network                                                                                                                                                                                                                               | Out-of-Network |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
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| 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. |                |
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\*After the Annual Medical Deductible has been met.

<sup>1</sup>Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

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

|                                                                                                                                                                                                                                                                                                                                                                   | Network                                                                           | Out-of-Network |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------|
| Mastectomy Services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                  | The amount you pay is based on where the covered health care service is provided. |                |
| Obesity - Weight Loss Surgery <sup>1</sup>                                                                                                                                                                                                                                                                                                                        | The amount you pay is based on where the covered health care service is provided. | Not covered    |
| 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 <sup>1</sup>                                                                                                                                                                                                                                                                                           | 20% *                                                                             | 50% *          |
| <i>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. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.</i> |                                                                                   |                |
| Reconstructive Procedures <sup>1</sup>                                                                                                                                                                                                                                                                                                                            | The amount you pay is based on where the covered health care service is provided. |                |
| Telehealth Services                                                                                                                                                                                                                                                                                                                                               | The amount you pay is based on where the covered health care service is provided. |                |
| Temporomandibular Joint (TMJ) Services <sup>1</sup>                                                                                                                                                                                                                                                                                                               | 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    |

\*After the Annual Medical Deductible has been met.

<sup>1</sup>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 |                                  |
| 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 \$                            | \$10                       | \$10                                         | \$25                             |
| 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.

## 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](https://welcometouhc.com) > **Benefits** > **Find a Doctor or Facility**.
- Choose **Search for a health plan**.
- Choose **Choice 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](https://welcometouhc.com) > **Benefits** > **Pharmacy Benefits**.
- Select **Access** to view the medications that are covered under your plan.



### Access your plan online.

With [myuhc.com](https://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/Child)
- Glasses
- 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](http://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](http://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.
- 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. This exclusion does not apply to outpatient prescription drugs prescribed for the Medically Necessary treatment of 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 as required for PKU as described under Enteral Nutrition in Section 1 of the 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 available.
- 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 available over-the-counter. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a provider for which Benefits are available, without cost sharing, as described under Section 5 of the Evidence of Coverage.
- 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 described under Off-Label Drug Use and Experimental or Investigational Services in Section 1 of the Certificate.
- 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).
- Medications used for cosmetic or convenience purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- 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, unless medically necessary.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

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:

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

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.

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

فيوغلل ا تدع اسملا تامدخ ناف ،(Arabic) فيببر عل ا ثدحتت تنك اذا :هي بنت  
 يل ع جردملا ين اجملا فتا امل ا مقرب لاصتالا ي جر ي اكل حاتم فين اجملا  
 اكب فصا امل ا فير عتلا فقا اطب

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 हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निशुल्क 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 vuaj cim ghia 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 sarिताem ti llocano (**llocano**), 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 avan iti identification card mo.

Díí BAA'ÁKONINÍZIN: Diné (**Navajo**) bizaad bee yánilti'go, saad bee áka'anida'awo'ígíí, t'áá jííkt'eh, bee ná'ahóót'i. T'áá shqódi ninaaltsoos nitl'izi bee nééhozinigíí bine'déé' t'áá jííkt'ehgo béesh 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 agoonsiga.

ગુજરાતી (**Gujarati**): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપય છે. મહેરબાની કરી તમારા આઈડી કાડડની સૂચી પર આપેલા સેમ્લે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.