

Heritage 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	Heritage Plus
 <p>Network coverage only You can usually save money when you receive care for covered health care services from network providers.</p>	<input type="checkbox"/>
 <p>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.</p>	<input checked="" type="checkbox"/>
 <p>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.</p>	<input type="checkbox"/>
 <p>Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.</p>	<input type="checkbox"/>
 <p>Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.</p>	<input checked="" type="checkbox"/>
 <p>Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.</p>	<input checked="" type="checkbox"/>
 <p>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.</p>	<input checked="" type="checkbox"/>
 <p>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.</p>	<input checked="" type="checkbox"/>
 <p>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.</p>	<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 Heritage Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$4,000	\$8,000
Family	\$8,000	\$16,000
Ped Dental Annual Deductible - Family	Included in your medical deductible	Included in your medical deductible
Ped Dental Annual Deductible - Individual	Included in your medical deductible	Included in your medical deductible

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

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.

*After the Annual Medical Deductible has been met.

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	\$6,000	\$14,000
Family	\$12,000	\$28,000

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	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	30%*
<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, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.</p>			
Office Services - Sickness & Injury			
Allergy Testing and Injections			
Allergy injections primary care physician office visit		No copay	30%*
Allergy injections specialist office visit		No copay*	30%*
Allergy testing primary care physician office visit		No copay	30%*
Allergy testing specialist office visit		No copay*	30%*

*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

	Designated Network	Network	Out-of-Network
Primary Care Physician			
Covered persons less than age 19	No copay	No copay	30%*
Injections other than allergy injections	No copay	No copay	30%*
Office surgery	No copay	No copay	30%*
Office visit for all other covered persons	\$35 copay	\$35 copay	30%*
Therapeutic Treatment Services	No copay	No copay	30%*
<i>Telemedicine is covered at the same cost share as in the office.</i>			
<i>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example lab work.</i>			
Specialist			
Injections other than allergy injections	No copay	No copay*	30%*
Office surgery	No copay	No copay*	30%*
Office visit	\$70 copay	\$95 copay	30%*
Therapeutic Treatment Services	No copay	No copay*	30%*
<i>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example lab work.</i>			
<i>Telemedicine is covered at the same cost share as in the office.</i>			
Urgent Care Center Services		\$50 copay	30%*
<i>Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example lab work.</i>			
Virtual Care Services		No copay	30%*
<i>Network 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.</i>			
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		No copay*	No copay*
Ground Ambulance		No copay*	No copay*
Ambulance Services - Non-Emergency Ambulance¹			
Air Ambulance		No copay*	No copay*
Ground Ambulance		No copay*	30%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

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

	Designated Network	Network	Out-of-Network
Dental Services - Accident Only		No copay*	No copay*
Emergency Health Care Services - Outpatient ¹			
Emergency Room		No copay*	No copay*
Emergency room physician		No copay*	No copay*
Inpatient Care			
Hospital - Inpatient Stay ¹		No copay*	30%*
Habilitative Services - Inpatient ¹	The amount you pay is based on where the covered health care service is provided.		
<i>Limited to 60 days per year.</i>			
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services ¹		No copay*	30%*
<i>Limited to 60 days per year.</i>			
Outpatient Care			
Habilitative Services - Outpatient		\$35 copay	30%*
<i>Limited to 20 visits of physical therapy per year.</i>			
<i>Limited to 20 visits of speech therapy per year.</i>			
<i>Limited to 20 visits of cognitive rehabilitation therapy per year.</i>			
<i>Limited to 20 visits of occupational therapy per year.</i>			
<i>Limited to 30 visits of post-cochlear implant aural therapy per year.</i>			
Home Health Care ¹		No copay*	30%*
<i>Limited to 60 visits per year.</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 ¹	\$15 copay	50%*	30%*
<i>Limited to 18 Presumptive Drug Tests per year.</i>			
<i>Limited to 18 Definitive Drug Tests per year.</i>			
<i>For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.</i>			

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

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

Major Diagnostic and Imaging - Outpatient¹

	Designated Network	Network	Out-of-Network
Major Diagnostic and Imaging - Outpatient ¹	No copay*	You pay a \$500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a \$500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%*
Primary care physician office visit	No copay*	You pay a \$500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a \$500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%*
Specialist office visit	No copay*	You pay a \$500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a \$500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%*

You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.

For Designated Network Benefits, radiology services must be received from a Designated Diagnostic Provider. Network Benefits include radiology services received from a Network provider that is not a Designated Diagnostic Provider.

Manipulative Treatment Services

\$35 copay

30%*

Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.

Physician Fees for Surgical and Medical Services

Inpatient facility visits

No copay*

30%*

Outpatient facility visits

No copay*

30%*

Physician house calls primary care physician

\$35 copay

\$35 copay

30%*

Physician house calls specialist

\$70 copay

\$95 copay

30%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

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

	Designated Network	Network	Out-of-Network
Rehabilitation Services - Outpatient Therapy		\$35 copay	30%*
<i>Limited to 36 visits of pulmonary rehabilitation therapy per year.</i>			
<i>Limited to 20 visits of occupational therapy per year.</i>			
<i>Limited to 30 visits of post-cochlear implant aural therapy per year.</i>			
<i>Limited to 20 visits of physical therapy per year.</i>			
<i>Limited to 20 visits of speech therapy per year.</i>			
<i>Limited to 36 visits of cardiac rehabilitation therapy per year.</i>			
<i>Limited to 20 visits of cognitive rehabilitation therapy per year.</i>			
<i>Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.</i>			
Surgery - Outpatient ¹			
For services provided at an ambulatory surgical center.		No copay*	30%*
For services provided at an outpatient hospital-based surgical center.		You pay a \$500 per occurrence deductible per date of service prior to and in addition to paying any Annual Deductible.*	You pay a \$500 per occurrence deductible per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%*
Therapeutic Treatments - Outpatient ¹			
All other therapeutic treatments Primary Care office visit		No copay	30%*
All other therapeutic treatments Specialist office visit		No copay*	30%*
All other therapeutic treatments facility		No copay*	30%*
Radiation therapy and intravenous chemotherapy Primary Care office visit		No copay	30%*
Radiation therapy and intravenous chemotherapy Specialist office visit		No copay*	30%*
Radiation therapy and intravenous chemotherapy facility		No copay*	30%*
Renal dialysis services Primary Care office visit		No copay	30%*
Renal dialysis services Specialist office visit		No copay*	30%*
Renal dialysis services facility		No copay*	30%*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>			
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing ¹		\$75 copay	30%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Supplies and Services			
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.		
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.		
Durable Medical Equipment (DME), Orthotics and Supplies ¹		\$250 copay per item*	30%*
Enteral Nutrition		No copay*	30%*
Hearing Aids		No copay*	30%*
<i>Limited to a single purchase per hearing impaired ear every three years.</i>			
<i>Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</i>			
Ostomy Supplies		No copay*	30%*
Prosthetic Devices ¹		\$250 copay per device*	30%*
Urinary Catheters		No copay*	30%*
Pregnancy			
Pregnancy - Maternity Services ¹	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		No copay*	30%*
Outpatient ¹		\$35 copay	30%*
Partial Hospitalization ¹		No copay*	30%*
Other Services			
Cellular and Gene Therapy ¹	The amount you pay is based on where the covered health care service is provided.		
<i>For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.</i>			
Clinical Trials ¹	The amount you pay is based on where the covered health care service is provided.		
Dental Anesthesia Services for Children	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

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

	Designated Network	Network	Out-of-Network
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Fertility Preservation for Iatrogenic Infertility¹

No copay*

30%*

Limited to \$5,000 for Prescription Drug Products per Covered Person.

Limited to \$20,000 per Covered Person per lifetime.

This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.

Gender Dysphoria¹

The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.

Hospice Care¹

No copay*

30%*

Preimplantation Genetic Testing (PGT) and Related Services¹

No copay*

30%*

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. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.

Reconstructive Procedures¹

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

Telemedicine Services

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

Temporomandibular Joint (TMJ) Services¹

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

Network Benefits must be received from a Designated Provider.

Pediatric Services - Dental

All Pediatric Dental - Benefits covered up to age 19

Additional limits may apply. Refer to your plan documents for more information.

Basic Dental Services

20%*

30%*

Diagnostic Services

No copay*

30%*

Limited to 2 evaluations (checkup exams) every 12 months.

Limited to 2 series of films every 12 months of Bitewing x-rays.

Limited to 1 time every 36 months for Panoramic x-rays.

Major Restorative Services

40%*

50%*

Medically Necessary Orthodontics¹

40%*

50%*

All orthodontic treatment must be prior authorized.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

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

	Designated Network	Network	Out-of-Network
Preventive Services		No copay*	30%*
<i>Limited to two dental prophylaxis cleanings and fluoride treatments every 12 months.</i>			
Pediatric Services - Vision			
Routine Vision Exam		\$10 copay	30%*
<i>Limited to once every 12 months.</i>			
All Pediatric Vision - Benefits Covered up to age 19			
Contact Lenses/Necessary Contact Lenses		\$25 copay	30%*
<i>Limited to a 12 month supply.</i>			
<i>Limited to one fitting and evaluation every 12 months.</i>			
<i>We will pay benefits for only one vision care service. You may choose either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses.</i>			
Eyeglass Frames			
Eyeglass frames with a retail cost below \$130.		No copay	30%*
Eyeglass frames with a retail cost between \$130-\$160.		\$15 copay	30%*
Eyeglass frames with a retail cost between \$160-\$200.		\$30 copay	30%*
Eyeglass frames with a retail cost between \$200-\$250.		\$50 copay	30%*
Eyeglass frames with a retail cost greater than \$250.		40%	30%*
<i>Limited to once every 12 months.</i>			
Eyeglass Lenses		\$25 copay	30%*
<i>Limited to once every 12 months.</i>			
Lens Extras		No copay	No copay*
<i>Limited to once every 12 months.</i>			
<i>Coverage includes polycarbonate lenses and standard scratch-resistant coating.</i>			
Low Vision Testing		No copay	25%*
<i>Limited to once every 24 months.</i>			
Low Vision Therapy		25%	25%*
<i>Limited to once every 24 months.</i>			

*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	Standard Select - Walgreens
Prescription Drug List	Essential w/ SMCS Drugs

In 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
	Retail Network	Retail Non-preferred Specialty Network Pharmacy	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 \$	\$10	Not applicable	\$10	\$30
Tier 2 \$\$	\$35	Not applicable	\$35	\$105
Tier 3 \$\$\$	\$140	Not applicable	\$140	\$420
Tier 4 \$\$\$\$	\$250	Not applicable	\$250	\$750
Preferred Specialty Prescription Drug Product Tier Level	Preferred Specialty Retail Network	Retail Non-preferred Specialty Network Pharmacy	Preferred Specialty Out-of-Network Pharmacy	Mail Order Preferred Specialty Network Pharmacy**
Tier 1 \$	\$10	\$10	\$10	Not covered***
Tier 2 \$\$	\$35	\$35	\$35	Not covered***
Tier 3 \$\$\$	\$140	\$140	\$140	Not covered***
Tier 4 \$\$\$\$	\$500	\$500	\$500	Not covered***

** 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.

For Specialty Drugs from a Non-Preferred Pharmacy, you will be required to pay the same Co-payment and/or Co-insurance as the Preferred Specialty Network Pharmacy based on the applicable Tier.

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.

*** Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

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://www.welcometouhc.com) > **Benefits** > **Find a Doctor or Facility**.
- Choose **Search for a health plan**.
- Choose **Heritage 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://www.welcometouhc.com) > **Benefits** > **Pharmacy Benefits**.
- Select **Essential** to view the medications that are covered under your plan.



Access your plan online.

With [myuhc.com](https://www.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.

- Long-Term Care
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs
- Dental Care (Adult)
- Routine Eye Care (Adult)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Infertility Treatment

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's 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 a mail order Network 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 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) 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 a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network 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 a mail order Network 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.

- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- 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 under Enteral Nutrition in Section 1 of the Certificate of Coverage.
- 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.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Experimental or Investigational or Unproven Services and medications. No prescribed drug will be excluded on the basis that the drug has not been approved by the United States Food and Drug Administration (FDA) for the indication for which the drug has been prescribed, if such drug is recognized in one of the standard reference compendia or in medical literature.
- 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 designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Medications used for cosmetic 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.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Drugs available over-the-counter.
- 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.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Durable Medical Equipment, including 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.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by 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.

تويوغللا تدع اسم الما تامدخ ناف، (Arabic) ةيبرعلا ثدحتت تنك اذا :هينبت
ىلع جردملا يئاجملا فتااملا مقرب لاصتالما يجرى. لكل ةحاتم ةيناجملا
كئب فصاخلا فيرعتملا قاطب

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisyè 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 हैं, आपको भाषा सहायता सेवाएं, नःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर काल 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 llocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqódí ninaaltsoos nitl'izi bee nééhozinígíí bine'déé' t'áá jíik'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 aqoonsiga.

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિ પર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.