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
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 Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Single Coverage	$2,250	$5,000
Family Coverage	$4,500	$10,000
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

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		
Single Coverage	$4,000	$10,000
Family Coverage	$8,000	$20,000

No one in the family is eligible for benefits until the family out-of-pocket maximum is met.

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 *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, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.*	No copay	30%*
Office Services - Sickness & Injury		
Primary Care Physician *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.*	No copay*	30%*
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.*	No copay*	30%*
Urgent Care *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*	No copay*	30%*

*After the Annual Medical Deductible has been met.

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

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Network	What You Pay for Services: Out-of-Network
Virtual Visits *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.*	No copay*	30%*
Vision Exams (Benefit is for Covered Persons over age 19) *Limited to 1 exam per year.* *Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.*	No copay	50%*
Emergency Care		
Accidental Dental	No copay*	No copay*
Emergency Ambulance	No copay*	No copay*
Emergency Room[1]	No copay*	No copay*
Non-Emergency Ambulance[1]	No copay*	30%*
Inpatient Care		
Congenital Heart Disease Surgeries[1]	No copay*	30%*
Hospital Inpatient Stays[1]	No copay*	30%*
Inpatient Habilitative Services[1]	The amount you pay is based on where the covered health care service is provided.	
Skilled Nursing Facility & Inpatient Rehabilitation Facility Services[1] *Limited to 100 days per Inpatient stay.*	No copay*	30%*
Outpatient Care		
Habilitative Services *Limited to 30 visits of speech therapy per year.* *Limited to 30 visits for any combination of physical or occupational therapy.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *The limits for physical, occupational, and speech therapy will not apply if care is part of the Hospice Care benefit. When you get physical, occupational, or speech therapy, or cardiac rehabilitation in the home, the home health care visit limit will apply instead of the therapy services limits. Benefits for Early Intervention Services and services for the treatment of Autism Spectrum Disorder are not subject to the annual limits.*	No copay*	30%*

*After the Annual Medical Deductible has been met.

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

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network	Out-of-Network
Home Health Care[1] *Limited to 100 visits per year for Home Health Care. 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. This home health care visit limit applies to any combination of physical, occupational, speech therapy, or cardiac rehabilitation received in the home instead of any individual therapy limits. This home health care limit does not apply to home infusion therapy or home dialysis. In accordance with Virginia law and as described in the Certificate of Coverage, Benefits are provided for home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital. Such visits are not subject to the above annual limits.*	No copay*	30%*
Lab Testing[1]	No copay*	30%*
Major Diagnostic and Imaging[1]	No copay*	30%*
Physician Fees for Surgical and Medical Services	No copay*	30%*
Rehabilitation Services *Limited to 30 visits of speech therapy per year.* *30 visits for any combination of physical or occupational therapy.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *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. Manipulative Treatment is covered under the Chiropractic Osteopathic / Manipulation Services category in this benefit summary.* *The limits for physical, occupational, and speech therapy will not apply if care is part of the Hospice Care benefit. When you get physical, occupational, or speech therapy, or cardiac rehabilitation in the home, the home health care visit limit will apply instead of the therapy services limits. Benefits for Early Intervention Services and services for the treatment of Autism Spectrum Disorder are not subject to the annual limits.*	No copay*	30%*
Scopic Procedures *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*	No copay*	30%*
Surgery[1]	No copay*	30%*
Therapeutic Treatments[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*	No copay*	30%*
X-ray and other Diagnostic Testing[1]	No copay*	30%*
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.	

*After the Annual Medical Deductible has been met.

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

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Diabetes Self-Management and Training[1]	The amount you pay is based on where the covered health care service is provided.	
Durable Medical Equipment, Orthotics and Supplies[1]	No copay*	30%*
Enteral Nutrition	No copay*	30%*
Hearing Aids *Limited to $1,500 every 24 months.* *Benefits are limited to a single purchase per hearing impaired ear. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*	No copay*	30%*
Ostomy and Urologic Supplies	No copay*	30%*
Pharmaceutical Products *This includes medications given at a doctor's office, or in a covered person's home.*	No copay*	30%*
Prosthetic Devices[1] *Limited to 1 wig per year for cancer treatment.*	No copay*	30%*
Urinary Catheters	No copay*	30%*
Pregnancy		
Maternity Services[1] *In accordance with Virginia law, Benefits are provided for certain home visits for mothers following obstetrical care in a Hospital, as prescribed by a Physician.*	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]	No copay*	30%*
Partial Hospitalization[1]	No copay*	30%*
Other Services		
Cellular or Gene Therapy[1] *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.	

*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	What You Pay for Services: Out-of-Network
Chiropractic Osteopathic / Manipulation Services *Limited to 30 visits per year.* *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. Manipulative Treatment is covered under the Chiropractic Osteopathic / Manipulation Services category in this benefit summary.* *Applies separately for rehabilitative and habilitative services for spinal manipulations and other manual medical interventions.*	No copay*	30%*
Cleft Lip and Cleft Palate Treatment[1]	No copay*	30%*
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.	
Congenital Defects and Birth Abnormalities[1]	No copay*	30%*
Dental Anesthesia and Facility Services	No copay*	30%*
Early Intervention Services[1]	No copay*	30%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Amendment.	
Home Treatment of Hemophilia and Congenital Bleeding Disorders[1]	No copay*	30%*
Hospice Care[1]	No copay*	30%*
Oral Surgery[1]	No copay*	30%*
Private Duty Nursing[1] *Private Duty Nursing services for a total of sixteen hours per year.*	No copay*	30%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint Services[1]	No copay*	30%*
Transplantation Services *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	
Pediatric Services - Dental		
All Pediatric Dental - Benefits covered up to age 19 *Additional limits may apply. Refer to your plan documents for more information.* *Additional limits may apply. Refer to your plan documents for more information.*		

*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
Basic Dental Services *Palliative (Emergency) treatment is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General anesthesia is covered only when clinically Necessary. Occlusal guards are limited to one guard every 12 months. Periodontal surgery is limited to one every 36 months per surgical area. Scaling and root planing are limited to one time per quadrant every 24 months. Periodontal maintenance is limited to four times every 12 months in combination with prophylaxis. Simple extractions (simple tooth removal) is limited to one time per tooth per lifetime.*	20%*	20%*
Diagnostic Services *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.*	No copay*	No copay*
Major Restorative Services	50%*	50%*
Medically Necessary Orthodontics[1] *All orthodontic treatment must be prior authorized.*	50%*	50%*
Preventive Services *Limited to two dental prophylaxis cleanings and flouride treatments every 12 months.*	No copay*	No copay*
Pediatric Services - Vision		
All Pediatric Vision - Benefits Covered up to age 19		
Contact Lenses/Necessary Contact Lenses *Limited to a 12 month supply.* *Limited to one fitting and evaluation every 12 months.* *We will pay benefits for only one vision care service. You may choose either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses.*	50%*	50%*
Eyeglass Frames		
Eyeglass frames with a retail cost below $130.	50%*	50%*
Eyeglass frames with a retail cost between $130-$160.	50%*	50%*
Eyeglass frames with a retail cost between $160-$200.	50%*	50%*
Eyeglass frames with a retail cost between $200-$250.	50%*	50%*
Eyeglass frames with a retail cost greater than $250. *Limited to once per year.*	50%*	50%*

*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
Eyeglass Lenses *Limited to once per year.*	50%*	50%*
Lens Extras *Coverage includes polycarbonate lenses and standard scratch-resistant coating.* *Limited to once per year.*	No copay*	No copay*
Low Vision Testing *Limited to once every 24 months.*	No copay	25%*
Low Vision Therapy *Limited to once every 24 months.*	25%	25%*
Routine Vision Exam *Limited to once per year.*	No copay	50%*

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

Pharmacy Benefits

	In Network
Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section

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

Annual Deductible - Network and Out-of-Network

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail Network	**Out-of-Network Pharmacy**	**Mail Order Network Pharmacy****
Tier 1 **$**	$10*	$10*	$20*
Tier 2 **$$**	$45*	$45*	$90*
Tier 3 **$$$**	20% however you will not pay less than $150*	20% however you will not pay less than $150*	20% however you will not pay less than $300*
Tier 4 **$$$$**	30% however you will not pay less than $300*	30% however you will not pay less than $300*	30% however you will not pay less than $600*

* After the Annual Medical 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. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy. 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 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) 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.

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

1 At the start of your plan year...

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

YOU PAY 100%

2 Once you reach your deductible...

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

YOU PAY 20%*

YOUR PLAN PAYS 80%

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

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

YOUR PLAN PAYS 100%

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

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

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

Search the network to find doctors.

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

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

Access your plan online.

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

Get on-the-go access.

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

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
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Weight Loss Programs
-
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Infertility Treatment
- Dental Care (Adult)

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.

- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product, unless Medically Necessary.
- Durable Medical Equipment 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.
- 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.
- Growth hormone therapy unless required by state law.
- 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.
- Diagnostic kits and products.
- 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.
- Prescription Drug Products when prescribed to treat infertility unless required by state law.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Drugs available over-the-counter.
- 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.
- Experimental or Investigational or Unproven Services and medications.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- 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 Medical Formulas for the treatment of inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies when prescribed by a Physician and deemed Medically Necessary to maintain adequate nutritional status.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- 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).

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 التعريف 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 yánílti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dę́ę́' 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 પ્રાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલા સભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.