# Select Plus plan details, all in one place

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

| Check out what's included in the plan | Select Plus |
|---|---|
| **Network coverage only**<br>You can usually save money when you receive care for covered health care services from network providers. | ☐ |
| **Network and out-of-network benefits**<br>You may receive care and services from network and out-of-network providers and facilities – but staying in the network can help lower your costs. | ☑ |
| **Primary care physician (PCP) required**<br>With this plan, you need to select a PCP – the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP. | ☑ |
| **Referrals required**<br>You'll need referrals from your PCP before seeing a specialist or getting certain health care services. | ☐ |
| **Preventive care covered at 100%**<br>There is no additional cost to you for seeing a network provider for preventive care. | ☑ |
| **Pharmacy benefits**<br>With this plan, you have coverage that helps pay for prescription drugs and medications. | ☐ |
| **Tier 1 providers**<br>Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings. | ☐ |
| **Freestanding centers**<br>You may pay less when you use certain freestanding centers – health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers. | ☐ |
| **Health savings account (HSA)**<br>With an HSA, you've got a personal bank account that lets you put money aside, tax-free.Use it to save and pay for qualified medical expenses. | ☐ |

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), Riders, and/or Amendments, those documents govern. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

# Here's a more in-depth look at how Select Plus works

## Medical Benefits

| | In Network | Out-of-Network |
|---|---|---|
| **Annual Medical Deductible** | | |
| Individual | $1,000 | $1,000 |
| Family | $2,000 | |

*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.*

| | | |
|---|---|---|
| **Annual Out-of-Pocket Limit** | | |
| Individual | $5,000 | |
| Family | $7,500 | |

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

*Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.*

### What You Pay for Services

| Copays ($) and Coinsurance (%) for Covered Health Care Services | Network | Out-of-Network |
|---|---|---|
| **Preventive Care Services** | | |
| Preventive Care Services<br><br>*Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.* | No copay | Not covered |
| **Office Services - Sickness & Injury** | | |
| Primary Care Physician<br><br>*Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.*<br><br>*Telehealth is covered at the same cost share as in the office.* | $40 copay | 50%* |

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to SPD.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | **Network** | **Out-of-Network** |
| Specialist<br><br>*Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.*<br><br>*Telehealth is covered at the same cost share as in the office.* | $40 copay | 50%* |
| Urgent Care Center Services | $40 copay | 50%* |
| Virtual Care Services<br><br>*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.* | $5 copay | Not covered |
| **Emergency Care** | | |
| Ambulance Services - Emergency Ambulance | | |
| Air Ambulance | 10%* | 10%* |
| Ground Ambulance<br><br>*Network Deductible applies to Out-of-Network benefits.* | 10%* | 10%* |
| Ambulance Services - Non-Emergency Ambulance[1] | | |
| Air Ambulance | 10%* | 50%* |
| Ground Ambulance | 10%* | 50%* |
| Dental Services - Accident Only<br><br>*Network Deductible applies to Out-of-Network benefits.* | 10%* | 10%* |
| Emergency Health Care Services - Outpatient[1]<br><br>*Network Deductible applies to Out-of-Network benefits.* | $250 copay | $250 copay |
| **Inpatient Care** | | |
| Congenital Heart Disease (CHD) Surgeries[1] | 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 SPD.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | Network | Out-of-Network |
| Habilitative Services - Inpatient[1]<br><br>*Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.* | The amount you pay is based on where the covered health care service is provided. | |
| Hospital - Inpatient Stay[1] | 10%* | 50%* |
| Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1]<br><br>*Limited to 100 days per year in a Skilled Nursing Facility.* | 10%* | 50%* |
| **Outpatient Care** | | |
| Habilitative Services - Outpatient<br><br>*Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.* | 10%* | 50%* |
| Home Health Care[1]<br><br>*Limited to 100 visits per year.*<br><br>*One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.* | 10%* | Not Covered |
| Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1] | 10%* | 50%* |
| Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1] | 10%* | 50%* |
| Major Diagnostic and Imaging - Outpatient[1] | 10%* | 50%* |
| Physician Fees for Surgical and Medical Services | 10%* | 50%* |
| Rehabilitation Services - Outpatient Therapy and Manipulative Treatment<br><br>*Limited to 30 visits of manipulative treatments per year.*<br><br>*Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.* | $40 copay | 50%* |
| Scopic Procedures - Outpatient Diagnostic and Therapeutic<br><br>*Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.* | 10%* | 50%* |

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

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | Network | Out-of-Network |
| Surgery - Outpatient[1] | 10%* | 50%* |
| Therapeutic Treatments - Outpatient[1]<br><br>*Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.* | 10%* | 50%* |
| **Supplies and Services** | | |
| Diabetes Self-Management Items[1] | 10% | 50%* |
| Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1] | $40 copay | 50%* |
| Durable Medical Equipment (DME), Orthotics and Supplies[1]<br><br>*Breast Pump covered at 10% Co-Insurance after Deductible. Out-of-Network is Not Covered* | 10%* | 50%* |
| Enteral Nutrition | 10%* | 50%* |
| Hearing Aids<br><br>*Limited to $2,000 per year.*<br><br>*Limited to a single purchase per hearing impaired ear every 3 years.*<br><br>*Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.* | 50%* | 50%* |
| Orthotics | 10%* | 50%* |
| Ostomy Supplies | 10%* | 50%* |
| Pharmaceutical Products - Outpatient<br><br>*This includes medications given at a doctor's office, or in a covered person's home.* | 10%* | 50%* |
| Prosthetic Devices[1] | 10%* | 50%* |
| Urinary Catheters | 10%* | 50%* |
| **Pregnancy** | | |
| Pregnancy - Maternity Services[1] | The amount you pay is based on where the covered health care service is provided. | |
| **Mental Health Care & Substance Related and Addictive Disorder Services** | | |
| Inpatient[1] | 10%* | 50%* |

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

| Copays ($) and Coinsurance (%) for Covered Health Care Services | What You Pay for Services | |
|---|---|---|
| | **Network** | **Out-of-Network** |
| Office Visit | $40 copay | 50%* |
| Outpatient | 10%* | 50%* |
| Partial Hospitalization[1] | 10%* | 50%* |
| **Other Services** | | |
| Acupuncture Services<br>*Limited to 30 treatments per year.* | $40 copay | 50%* |
| Cellular and Gene Therapy<br>*For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.* | The amount you pay is based on where the covered health care service is provided. | Not covered |
| Clinical Trials[1] | The amount you pay is based on where the covered health care service is provided. | |
| Gender Dysphoria[1] | The amount you pay is based on where the covered health care service is provided. | |
| Hospice Care[1] | 10%* | 50%* |
| Obesity - Weight Loss Surgery<br>*For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.* | The amount you pay is based on where the covered health care service is provided. | Not covered |
| Reconstructive Procedures[1] | The amount you pay is based on where the covered health care service is provided. | |
| Temporomandibular Joint (TMJ) Services[1] | 10%* | 50%* |
| Transplantation Services<br>*Network Benefits must be received from a Designated Provider.* | The amount you pay is based on where the covered health care service is provided. | Not covered |

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

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

### 1 At the start of your plan year...

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

YOU PAY 100%

### 2 Once you reach your deductible...

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

YOU PAY 20%*

YOUR PLAN PAYS 80%

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

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

YOUR PLAN PAYS 100%

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

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

## Digital tools to keep you connected

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

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

### Get connected

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

# Other important information about your benefits

### Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your SPD, 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 Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs
- Wigs

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

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

**Online: UHC_Civil_Rights@uhc.com**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



United Healthcare®