

## What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

## What are the benefits of the Options PPO Plan?

### Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

- > **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.
- > **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.
- > **Preventive care is covered 100% in our network.**

### Are you a member?

Easily manage your benefits online at [myuhc.com](http://myuhc.com)® and on the go with the **UnitedHealthcare Health4Me**® mobile app.

For questions, call the member phone number on your health plan ID card.

**Not enrolled yet?** Learn more about this plan and search for network doctors or hospitals at [welcometouhc.com/optionsppo](http://welcometouhc.com/optionsppo) or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

## Benefits At-A-Glance

### What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-insurance	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
10%	\$100	10%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. 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.

## Your Costs

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In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

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### Your cost if you use Network Benefits

### Your cost if you use Out-of-Network Benefits

#### Annual Deductible Combined Network and Non-Network

##### What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

- > All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	\$100 per year	\$100 per year
Medical Deductible - Family	\$300 per year	\$300 per year

#### Out-of-Pocket Limit Combined Network and Non-Network

##### What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

- > Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.
- > All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

Out-of-Pocket Limit - Individual	\$2,500 per year	\$2,500 per year
Out-of-Pocket Limit - Family	\$7,500 per year	\$7,500 per year

## Your Costs

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### **What is co-insurance?**

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

### **What is a co-payment?**

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, \$50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

### **What is Prior Authorization?**

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

### **Want more information?**

Find additional definitions in the glossary at [justplainclear.com](http://justplainclear.com).

## Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Ambulance Services</b>		
Emergency Ambulance	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the medical deductible has been met.  Prior Authorization is required for Non-Emergency Ambulance.
<b>Autism Spectrum Disorder</b>		
	The amount you pay is based on where the covered health care service is provided.  Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
<b>Blood and Blood Products</b>		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
<b>Clinical Trials</b>		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
<b>Congenital Heart Disease Surgeries</b>		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
<b>Dental Services - Accident Only</b>		
	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the network medical deductible has been met.  Prior Authorization is required.
<b>Diabetes Services</b>		
Diabetes Self Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self Management Items:	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 Outpatient Prescription Drug Rider.	Prior Authorization is required for DME that costs more than \$1,000.

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Durable Medical Equipment (DME), Orthotics and Supplies</b>		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required for DME or orthotics that costs more than \$1,000.
<b>Emergency Health Care Services - Outpatient</b>		
	10% co-insurance. A deductible does not apply.	10% co-insurance. A deductible does not apply.  Notification is required if confined in an Out-of-Network Hospital.
<b>Gender Dysphoria</b>		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required for certain services.
<b>Habilitative Services</b>		
<p>Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.</p>	The amount you pay is based on where the covered health care service is provided.	
<p>Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.</p>	10% co-insurance. A deductible does not apply.	<p>30% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for certain services.</p>

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Hearing Aids</b>		
<p>Limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</p>	<p>10% co-insurance, after the medical deductible has been met.</p>	<p>30% co-insurance, after the medical deductible has been met.</p>
<b>Home Health Care</b>		
<p>Limited to 150 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</p>	<p>You pay nothing. A deductible does not apply.</p>	<p>30% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required.</p>
<b>Hospice Care</b>		
	<p>You pay nothing. A deductible does not apply.</p>	<p>30% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for Inpatient Stay.</p>
<b>Hospital - Inpatient Stay</b>		
	<p>10% co-insurance. A deductible does not apply.</p>	<p>30% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required.</p>
<b>In Vitro Fertilization - Outpatient</b>		
<p>Limited to outpatient services for one in vitro fertilization attempt the entire period of time you are enrolled under the Policy.</p>	<p>The amount you pay is based on where the covered health care service is provided.</p> <p>Benefits for Outpatient prescription medication are provided under the Outpatient Prescription Drug Rider.</p>	<p>Prior Authorization is required.</p>
<b>Lab, X-Ray and Diagnostic - Outpatient</b>		
<p>Lab Testing - Outpatient</p>	<p>10% co-insurance. A deductible does not apply.</p>	<p>30% co-insurance, after the medical deductible has been met.</p>
<p>X-Ray and Other Diagnostic Testing - Outpatient</p>	<p>10% co-insurance. A deductible does not apply.</p>	<p>30% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required for certain services.</p>
<b>Major Diagnostic and Imaging - Outpatient</b>		
	<p>10% co-insurance. A deductible does not apply.</p>	<p>30% co-insurance, after the medical deductible has been met.</p> <p>Prior Authorization is required.</p>

## Your Costs

<b>Covered Health Care Services</b>	<b>Your cost if you use Network Benefits</b>	<b>Your cost if you use Out-of-Network Benefits</b>
<b>Medical Foods</b>		
	10% co-insurance. A deductible does not apply.	20% co-insurance. A deductible does not apply.  Prior Authorization is required.
<b>Mental Health Care and Substance - Related and Addictive Disorders Services</b>		
Inpatient:	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Outpatient:	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required for certain services.
<b>Obesity Surgery</b>		
	The amount you pay is based on where the covered health care service is provided.	  Prior Authorization is required.
<b>Orthodontic Services for Treatment of Orofacial Anomalies</b>		
Limited to \$5,500 per treatment phase.	You pay nothing. A deductible does not apply.	You pay nothing. A deductible does not apply.  Prior Authorization is required.
<b>Ostomy Supplies</b>		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
<b>Physician Fees for Surgical and Medical Services</b>		
	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Physician's Office Services - Sickness and Injury</b>		
	10% co-insurance for a primary care physician office visit. A deductible does not apply.  10% co-insurance for a specialist office visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required for Genetic Testing.
<b>Pregnancy - Maternity Services</b>		
	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.	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
<b>Prescription Drug Benefits</b>		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
<b>Preventive Care Services</b>		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	You pay nothing after the medical deductible has been met for immunizations. 30% co-insurance for all other Covered Health Care Services after the medical deductible has been met. A deductible does not apply to child health supervision services and screening mammography.
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 co-pay, co-insurance or deductible.		
<b>Prosthetic Devices</b>		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required for Prosthetic Devices that costs more than \$1,000.



## Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
<b>Reconstructive Procedures</b>		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
<b>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</b>		
Limited to: 20 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 60 visits of physical therapy. 60 visits of occupational therapy. 60 visits of speech therapy. 30 visits of post-cochlear implant aural therapy.	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required for certain services.
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Skilled Nursing Facility Services Limited to 120 days per year.	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required.
<b>Surgery - Outpatient</b>		
	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required for certain services.
<b>Telehealth Services</b>		
	The amount you pay is based on where the covered health care service is provided.  Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

## Your Costs

<b>Covered Health Care Services</b>	<b>Your cost if you use Network Benefits</b>	<b>Your cost if you use Out-of-Network Benefits</b>
<b>Therapeutic Treatments - Outpatient</b>		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required for certain services.
<b>Transplantation Services</b>		
Network Benefits must be received from a Designated Provider.	You pay nothing. A deductible does not apply.  Prior Authorization is required.	30% co-insurance, after the medical deductible has been met.  Prior Authorization is required.
<b>Urgent Care Center Services</b>		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
<b>Virtual Visits</b>		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at <a href="http://myuhc.com">myuhc.com</a> <sup>®</sup> 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.	10% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
<b>Vision Exams</b>		
Find a listing of Spectera Eyecare Network Vision Care Providers at <a href="http://myuhcvision.com">myuhcvision.com</a> .		
Limited to 1 exam every 12 months.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

## Services your plan does not cover (Exclusions)

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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.

### Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; adventure-based therapy, wilderness therapy, outdoor therapy or similar programs, art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

### Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: removal, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). This exclusion does not apply to orthodontic services for which Benefits are provided under Orthodontic Services for Treatment of Orofacial Anomalies in Section 1 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

### Devices, Appliances and Prosthetics

Devices used as safety items or to help performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. This exclusion does not apply to: Foot orthotics for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC; foot orthotics for Covered Persons with partial foot amputations; foot orthotics that are an integral part of a leg brace; foot orthotics prescribed as part of post-surgical or post-traumatic casting care. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Oral appliances for snoring. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

## Services your plan does not cover (Exclusions)

### Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to contraceptives, diabetic supplies and outpatient prescription medication and prescription drug products for which Benefits are provided as described under Preventive Care Services and Diabetes Services in Section 1 of the COC. Self-injectable medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to contraceptive and diabetic prescription medications for which Benefits are provided as described under Preventive Care Services and Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. This exclusion does not apply if it is for replacement therapy services to treat hypothalamic-pituitary damage caused by primary brain tumors, trauma, infection, or radiation therapy, Turner's syndrome, growth failure secondary to chronic renal insufficiency awaiting renal transplant, AIDS-wasting or cachexia without evidence of suspected or overt malignancy and where other modes of nutritional supplements have been tried, short stature, neonatal hypoglycemia secondary to growth hormone deficiency, Prader-Willi Syndrome, or severe growth hormone deficiency in adults. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

### Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

### Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics (this exclusion does not apply to Foot orthotics for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC, foot orthotics for Covered Persons with partial foot amputations, foot orthotics that are an integral part of a leg brace, or foot orthotics prescribed as part of post-surgical or post-traumatic casting care); shoe inserts and arch supports.

## Services your plan does not cover (Exclusions)

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### Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

### Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices in Section 1 of the COC. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.

Tubing and masks except when used with DME as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

### Mental Health Care and Substance-Related and Addictive Disorders

Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Transitional Living services.

### Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to nutritional counseling for the treatment of eating disorders for which Benefits are provided as described under Physician's Office Services - Sickness and Injury in Section 1 of the COC. This exclusion also does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula and donor breast milk. This exclusion does not apply to Medical Foods for which Benefits are provided as described under Additional Benefits Required by Hawaii Law - Medical Foods in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. This exclusion does not apply to Medical Foods for which Benefits are provided as described under Additional Benefits Required by Hawaii Law - Medical Foods in Section 1 of the COC.

## Services your plan does not cover (Exclusions)

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### Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

### Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness or flexibility. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

### Procedures and Treatments

Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment. Habilitative services for maintenance/preventive treatment. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident or stroke. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. This exclusion does not apply to services in connection with the initial visit for diagnosis of temporomandibular joint (TMJ) problems. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea or to services in connection with the initial visit for diagnosis of malocclusion of the teeth or jaws. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Helicobacter pylori (H. pylori) serologic testing.

### Providers

Services performed by a provider who is a family member by birth or marriage, limited to spouse, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence, limited to spouse, parent or child.

## Services your plan does not cover (Exclusions)

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### Reproduction

Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under In Vitro Fertilization in Section 1 of the COC. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus. The exclusion of surrogate parenting does not apply when the Covered Person is the surrogate for which Benefits are available as described under Pregnancy - Maternity Services in Section 1 of the COC. The reversal of voluntary sterilization. This exclusion does not apply to Benefits for elective abortions, vasectomies and tubal ligations. Coverage for these services will be provided at the level as any other Covered Health Service.

### Services Provided under Another Plan

Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health care services during active military duty.

### Transplants

Health care services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health care services for transplants involving permanent mechanical or animal organs.

### Travel

Health care services provided in a foreign country, unless required as Emergency Health Care Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

### Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care aides. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

### Vision and Hearing

Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to eyeglasses or contact lenses prescribed for certain medical conditions such as aphakia, cataract, and keratoconus or to pediatric vision services for which Benefits are provided as described in the Pediatric Vision Care Services Rider. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid. You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

## Services your plan does not cover (Exclusions)

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### All Other Exclusions

Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Care Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when: required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders. (This exclusion does not apply to services that are determined to be Medically Necessary). Conducted for purposes of medical research (This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to get or maintain a license of any type. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country, to the extent permitted by law. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the co-payments, co-insurance and/or deductible are waived. Charges in excess of the Allowed Amount or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

**For Internal Use only:**

**HIMAE06AGRO18**

**Item#      Rev. Date**

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Base/Value/Sep/Emb/47898/2018



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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 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, 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. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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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 **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

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)**, udostępniłiśmy 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.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री फ़ोन नंबर पर काल करें।

CEEBOOM: 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.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**Khmer (Khmer)** សេវាជំនួយភាសាខ្មែរឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខគិតគំរៃថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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 yánit'i'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqòdí ninaaltsoos nit'izí bee nééhozinígíí bine'déé' t'áá jíik'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.

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Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to [myuhc.com](http://myuhc.com)® or calling the Customer Care number on your ID card.

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#### Annual Drug Deductible - Network and Out-of-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

#### Out-of-Pocket Drug Limit - Network

Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

Out-of-Pocket Limit does not apply to Out-of-Network Charges and Coupons.

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This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

Tier Level	Up to 31-day supply	Up to 90-day supply
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	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	Retail Out-of-Network Pharmacy	*Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy
<b>Tier 1 Prescription Drug Products</b>	<b>\$10</b>	<b>\$10</b>	<b>\$30</b>
<b>Tier 2 Prescription Drug Products</b>	<b>\$30</b>	<b>\$30</b>	<b>\$90</b>
<b>Tier 3 Prescription Drug Products</b>	<b>\$50</b>	<b>\$50</b>	<b>\$150</b>

**In Vitro Fertilization Maximum Policy Benefit**

The maximum amount we will pay for covered Prescription Drug Products for In vitro fertilization during the entire period of time you are enrolled for coverage under the Policy.

Prescription Drug Products for in vitro fertilization are limited to Prescription Drug Products necessary, as determined by your Physician, for one in vitro fertilization attempt per Covered Person for the entire period of time you are enrolled under the Policy.

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

\* Only certain Prescription Drug Products are available through mail order; please visit [myuhc.com](http://myuhc.com)<sup>®</sup> 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.

## Other Important Information about your Outpatient Prescription Drug Benefits

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or 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 applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, 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](http://myuhc.com)<sup>®</sup> 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.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at [myuhc.com](http://myuhc.com)<sup>®</sup> or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail 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 Retail Network Pharmacy.

Certain Preventive Care Medications maybe covered. You can get more information by contacting us at [myuhc.com](http://myuhc.com)<sup>®</sup> 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](http://myuhc.com)<sup>®</sup> 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.

## PHARMACY EXCLUSIONS

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The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

### Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- 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, Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- 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, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug 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 Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products for in vitro fertilization for which Benefits are provided as described in Section 1 of the COC.
- Certain Prescription Drug Products for tobacco cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- 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 for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any oral non-sedating antihistamine or antihistamine-decongestant combination.
- 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 for Medical Foods and Low Protein Modified Food Products for the treatment of Inborn Error of Metabolism as described under Medical Foods in Section 1 of the COC.

## PHARMACY EXCLUSIONS CONTINUED

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- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.
- A Prescription Drug Product with either an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following: it is highly similar to a reference product (a biological Prescription Drug Product) and it has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Treatment for toenail Onychomycosis (toenail fungus).

**HIMPMAAO418**

**Item#      Rev. Date**

999-4599    0320      Standard/Sep/Advantage/47899/2018

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

**Online:** UHC\_Civil\_Rights@uhc.com

**Mail:** Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 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, 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. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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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 **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.



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)**, udostępniłiśmy 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.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री फोन नंबर पर काल करें।

CEEBOOM: 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.

ចំណាប់អារម្មណ៍: បើសិនជាអ្នកនិយាយ**khmer (Khmer)** សេវាជំនួយភាសាសម្រាប់អ្នកដែលនិយាយភាសាខ្មែរ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខតេឡេហ្វូន ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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 yánit'i'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shqoqí ninaaltsoos nit'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodílnih.

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.

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