UnitedHealthcare®

Benefit Summary

Missouri - Choice Plus
Premier - Plan ABKQ Modified4

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 services, when possible.

What are the benefits of the UnitedHealthcare Tiered Benefit Plus Plan?

Get more protection with a national network and save with Tier 1 providers.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care from anyone in or out of our network, but you can save more money when you use the network. You can save even more when you use UnitedHealth Premium® Tier 1 providers.

> **Pay less by using UnitedHealth Premium Tier 1 providers.** They have been recognized for providing value.

> **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.**

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **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.

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-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$30	$1,500	20%

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), 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.

UnitedHealthcare Insurance Company

Your Costs

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

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

Deductible

What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.

> 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.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Medical Deductible - Individual	$1,500 per year	$3,000 per year
Medical Deductible - Family	$3,000 per year	$6,000 per year

Out-of-Pocket Limit

What is an out-of-pocket limit?

The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

> 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.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Out-of-Pocket Limit - Individual	$6,350 per year	$13,000 per year
Out-of-Pocket Limit - Family	$12,700 per year	$26,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. 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 (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at 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.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services - Emergency and Non-Emergency		
	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	20% co-insurance, after the network medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorders Treatment		
	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for Autism Spectrum Disorders Treatment during a Physician's office visit will be the same as found under Physician's Office - Sickness and Injury in this Benefit Summary. Benefits for Therapeutic Treatments for Autism Spectrum Disorders will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary.	Prior Authorization is required.
Chiropractic Services		
Co-insurance will not exceed 50% of the total cost of any single chiropractic service provided within the scope of a chiropractor's license as defined by Missouri law. No visit limit applies and there is no prior authorization required.	50% co-insurance. A deductible does not apply.	50% co-insurance. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees Limits for Clinical Trials routine care are the same as limits for any other physical sickness.	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for a clinical trial during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for a Physician's office visit associated with a clinical trial will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for laboratory services associated with a clinical trial will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Anesthesia and Facility Charges		
	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for dental anesthesia received on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under Physician Fees for Surgical and Medical Services in this Benefit Summary.	
		Prior Authorization is required.
Dental Services - Accident Only		
	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.	20% co-insurance, after the network medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for diabetic eye examinations performed in a Physician's office will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for a Physician's office visit associated with diabetes self-management and training will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for diabetic foot care for surgeries performed on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary.	
Diabetes Self Management Items	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for diabetes self-management items related to Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for diabetes self-management items related to prescribed items obtained at a pharmacy can be found in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Early Intervention Services		
	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for early intervention services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for early intervention services that are considered rehabilitation services will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary.	Prior Authorization is required.
Emergency Health Services - Outpatient		
	$150 co-pay per visit. A deductible does not apply.	$150 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Enteral Formulas and Low Protein Modified Foods Products		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Hearing Aids		
Limited to $2,500 per year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years. This limit does not apply to Newborns.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Hearing Screening for Newborns		
	You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 visits per year.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Hospital - Inpatient Stay		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Human Leukocyte Testing		
	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for laboratory tests related to human leukocyte testing will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for human leukocyte testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for sleep studies.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lead Poisoning Testing		
	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for lead poisoning testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for lead poisoning testing that are preventive in nature will be the same as found under Preventive Care Services in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to lead poisoning will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary.	
Mental Health Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Osteoporosis Services		
	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for osteoporosis services that are preventive in nature will be the same as found under Preventive Care Services in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to osteoporosis services will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for osteoporosis services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	
Ostomy Supplies		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	Designated Network: 20% co-insurance for primary care visits, after the medical deductible has been met. 20% co-insurance for specialist care visits, after the medical deductible has been met. Network: 20% co-insurance for primary care visits, after the medical deductible has been met. 20% co-insurance for specialist care visits, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	Covered persons less than age 19: You pay nothing. A deductible does not apply. All other Covered Persons: Designated Network: $30 co-pay per visit. A deductible does not apply. Network: $30 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	Designated Network: $30 co-pay per visit. A deductible does not apply. Network: $60 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Pregnancy - Maternity Services

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.

The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following:

Benefits for Pregnancy during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary.

Benefits for laboratory services associated with Pregnancy will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary.

Benefits for pharmaceutical products for Pregnancy received on an outpatient basis will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary.

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.

Prescription Drug Benefits

Prescription drug benefits are shown in the Prescription Drug benefit summary.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests. You are not required to pay any co-payments or co-insurance or meet any deductible for immunizations for Enrolled Dependent children from birth to age five.	You pay nothing. A medical deductible does not apply.	40% co-insurance, after the medical deductible has been met. You pay nothing. A medical deductible does not apply for child immunizations to age five.
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.		
Prosthetic and Orthotic Devices		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for reconstructive procedures during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for reconstructive procedures during outpatient surgery will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for reconstructive procedures received during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	
		Prior Authorization is required.
Rehabilitation and Habilitative Services - Outpatient Therapy		
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of pulmonary rehabilitation. 36 visits of cardiac rehabilitation. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. Limits do not apply to Therapeutic Care for the treatment of Autism Spectrum Disorder.	$30 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Speech and Hearing Services		
	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for speech and hearing therapy related to rehabilitation will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for speech and hearing services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under Lab, X-ray and Diagnostics - Outpatient in this Benefit Summary.	
Substance Use Disorder Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Surgery - Outpatient		
	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telehealth		
	The amount you pay is based on where the covered health service is provided.	

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Examples include but are not limited to the following: Benefits for transplantation services during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for transplantation services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for transplantation services during outpatient surgery will be the same as found under Surgery - Outpatient in this Benefit Summary.	
	Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$50 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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.	$20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Vision Examination		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 24 months.	$20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

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; 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 chiropractic services or non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Autism Spectrum Disorders Treatment

Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health 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 Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, except as described under Dental Anesthesia and Facility Charges in Section 1 of the COC). 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 cancer, cleft palate or diseases of the mouth and if Injury to the tooth was a serious Injury as described under Dental Services - Accident Only in Section 1 of the COC. 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 dental caries 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: extraction, 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 accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental 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). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Services your plan does not cover (Exclusions)

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect 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 items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities (This exclusion does not apply to foot orthotics described for which coverage is described under Durable Medical Equipment in Section 1 of the COC). Cranial banding. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses (This exclusion does not apply to trusses described under Durable Medical Equipment in Section 1 of the COC) and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. This exclusion does not apply to assistive technology devices for children from birth to age three who are eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. 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 consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. 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.

Experimental, 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 for Covered Persons with 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 for Covered Persons who 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 (This exclusion does not apply to built-up shoes); shoe orthotics; shoe inserts and arch supports.

Medical Supplies

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

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under Autism Spectrum Disorders treatment in section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions identified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health 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 Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided 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 an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to enteral formulas for Covered Persons under the age 6, for which Benefits are provided as described under Enteral Formulas and Low Protein Modified Food Products in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to enteral formulas for Covered Persons under age 6, for which Benefits are provided as described under Enteral Formulas and Low Protein Modified Food Products in Section 1 of the COC.

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 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.

Services your plan does not cover (Exclusions)

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 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 initial 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, body-building, exercise, fitness, flexibility, and diversion or general motivation. 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

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, 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 to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. This does not apply to Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy when not Medically Necessary for chronic or progressive conditions such as cerebral palsy, Alzheimer's disease or Parkinson's disease. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant 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. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of dislocation, tumors, cancer, obstructive sleep apnea or a Congenital Anomaly or Injury as described in the Reconstructive Procedures Benefit in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking 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. In vitro fertilization regardless of the reason for treatment.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, 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. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Services your plan does not cover (Exclusions)

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health Services and associated expenses for surgical, non-surgical or drug induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy or missed abortion (commonly known as a miscarriage). This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female upon whom the abortion is performed. Fetal reduction surgery. This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female whom the abortion is performed.

Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health 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 Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health 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 services for transplants involving permanent mechanical or animal organs.

Travel

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

Services your plan does not cover (Exclusions)

Types of Care

Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct 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: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied 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 the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health 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 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, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (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); required to obtain or maintain a license of any type. Health 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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to Section 4 of the COC. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses 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 services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health 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.

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UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Missouri
10/35/60 Plan 2V

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 **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Non-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network

Individual Out-of-Pocket Limit	See Medical Benefit Summary
Family Out-of-Pocket Limit	See Medical Benefit Summary

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

Benefit Plan Co-payment/Co-insurance - The amount you pay.

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 2	**$35**	**$35**	**$87.50**
Tier 3	**$60**	**$60**	**$150**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

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.

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Item# **Rev. Date**
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UnitedHealthcare Insurance Company

Other Important Information about your Outpatient Prescription Drug Benefits

If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

You are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the retail Network Pharmacy's Usual and Customary Charge or the Prescription Drug Charge for that Prescription Drug Product, or the lowest of the applicable Co-payment and/or Co-insurance, the mail order Network Pharmacy's Usual and Customary Charge or Prescription Drug Charge for that Prescription Drug Product.

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.

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. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drug Products require that you obtain prior authorization from us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

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 Non-Network Benefit for that Prescription Drug Product.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program each year through the Internet at myuhc.com or by calling Customer Care at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below 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 indications 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 rising 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 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.
- Certain Prescription Drug Products for smoking 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 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 the highest Tier.)
- 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 comprised 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 assigned to 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 Prescription Drug Products for enteral formulas prescribed for the treatment of phenylketonuria or any inherited disease of amino and organic acids.
- 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 schedule, such as for jet lag or shift work.
- Prescription Drug Products when used for 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 Physician.
- 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 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 showing that it is highly similar to a reference product (a biological Prescription Drug 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 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.

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 member 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 member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

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 معرّف 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)**, 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.

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।

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.

ចំណាប់អារម្មណ៍៖ បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ 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 yániłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dę́ę́' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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