UnitedHealthcare®

Benefit Summary

UHC Navigate Gold 500
Colorado - Navigate
Navigate Direct - Plan AK2U

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 Navigate® Direct Plan?

Get a plan with a Primary Care Provider (PCP) to help coordinate your care.

This is a health plan that requires you to select a PCP who can help guide you through the health care system so you can get the right care at the right time.

> **Select your personal PCP from the plan network.** Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care. You need to get online referrals from your PCP to see a network specialist.

> **Pay less by using certain freestanding centers.** Freestanding centers are health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.

> **There's no coverage if you go out of the network.** You will be responsible for the entire cost of the service.

> **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)
$20	$500	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), 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 of Colorado, Inc.

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

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.

> This benefit plan includes a per occurrence deductible that applies to certain common medical events. This per occurrence deductible must be met prior to and in addition to the medical deductible.

Medical Deductible - Individual	$500 per year
Medical Deductible - Family	$1,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.

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, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$5,000 per year
Out-of-Pocket Limit - Family	$10,000 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
Ambulance Services	
Emergency	10% co-insurance, after the medical deductible has been met.
Non-Emergency	10% co-insurance, after the medical deductible has been met.
Autism Spectrum Disorder	
	The amount you pay is based on where the covered health service is provided.
Bariatric Surgery	
Obesity surgery is covered when received at a designated facility and performed by a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.	The amount you pay is based on where the covered health service is provided.
Cleft Lip and Cleft Palate Treatment	
	The amount you pay is based on where the covered health service is provided.
Clinical Trials	
	The amount you pay is based on where the covered health service is provided.
Colorectal Cancer Screening	
	The amount you pay is based on where the covered health service is provided. The screening for the early detection of colorectal cancer and adenomatous polyps is not subject to any deductibles.
Congenital Heart Disease (CHD) Surgeries	
	10% co-insurance after you pay the $500 per occurrence deductible per Inpatient Stay and the medical deductible has been met (with a referral from your Primary Physician).
Dental - Pediatric Services (Benefits covered up to age 19)	
Benefits provided by the National Options PPO 20 Network (INO-MAC).	

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Preventive Services	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to 2 times per 12 months.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.
Space Maintainers Benefit includes all adjustments within 6 months of installation.	You pay nothing, after the medical deductible has been met.
Dental - Pediatric Diagnostic Services	
Periodic Oral Evaluation (Check-up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing, after the medical deductible has been met.
Radiographs Limited to 2 series of films per 12 months for Bitewing and 1 time per 36 months for Complete/Panorex.	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Basic Dental Services	
Endodontics (Root Canal Therapy)	40% co-insurance, after the medical deductible has been met.
General Services (Including Emergency treatment) Palliative Treatment: Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General Anesthesia: Covered when clinically necessary. Occlusal Guard: Limited to 1 guard every 12 months and only covered if prescribed to control habitual grinding.	40% co-insurance, after the medical deductible has been met.
Oral Surgery (Including Surgical Extractions)	40% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to 1 quadrant or site per 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per 24 months. Periodontal Maintenance: Limited to 4 times per 12 months. In conjunction with dental prophylaxis, following active and adjunctive periodontal therapy, exclusive of gross debridement.	40% co-insurance, after the medical deductible has been met.
Restorations (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as one filling.	40% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	40% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Major Restorative Services	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months.	50% co-insurance, after the medical deductible has been met.
Dentures and other removable Prosthetics (Full denture/partial denture) Limited to 1 time per 60 months.	50% co-insurance, after the medical deductible has been met.
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per 60 months.	50% co-insurance, after the medical deductible has been met.
Implants Limited to 1 time per tooth per 60 months.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Medically Necessary Orthodontics	
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance, after the medical deductible has been met.
Dental Services - Accident Only	
	10% co-insurance, after the medical deductible has been met.
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.
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.
Durable Medical Equipment	
	10% co-insurance, after the medical deductible has been met.
Emergency Health Services - Outpatient	
	$400 co-pay per visit. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Hearing Aids for Adults	
Limited to a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	10% co-insurance, after the medical deductible has been met.
Hearing Aids for Minor Children	
Limited to a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	10% co-insurance, after the medical deductible has been met.
Home Health Care	
Limited to 364 visits per year.	10% co-insurance, after the medical deductible has been met.
Hospice Care	
	10% co-insurance, after the medical deductible has been met.
Hospital - Inpatient Stay	
This Benefit includes Private Duty Nursing provided on an inpatient basis only when skilled nursing care is not available from the Hospital.	10% co-insurance after you pay the $500 per occurrence deductible per Inpatient Stay and the medical deductible has been met (with a referral from your Primary Physician).
Hospitalization and General Anesthesia for Dental Procedures for Children	
	The amount you pay is based on where the covered health service is provided.
Infertility Services	
For Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician.	10% co-insurance, after the medical deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient	
	You pay nothing for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office. A deductible does not apply. $250 per occurrence deductible per service for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	10% co-insurance, after the medical deductible has been met for services provided at a freestanding diagnostic center or in a physician's office. 10% co-insurance after you pay the $500 per occurrence deductible per service and the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.
Mental Health Services (Biologically and Non-Biologically Based Mental Illness)	
Inpatient:	10% co-insurance, after the medical deductible has been met.
Outpatient:	$40 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.
Neurobiological Disorders – Autism Spectrum Disorder Services	
Inpatient:	10% co-insurance, after the medical deductible has been met.
Outpatient:	$40 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.
Ostomy Supplies	
Limited to $2,500 per year.	10% 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.	10% co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) Testing and Treatment	
	The amount you pay is based on where the covered health service is provided.
Physician Fees for Surgical and Medical Services	
	10% co-insurance, after the medical deductible has been met for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 10% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Physician's Office Services - Sickness and Injury	
	$20 co-pay per visit for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. A deductible does not apply. $40 co-pay per visit (with a referral from your Primary Physician). A deductible does not apply.

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

Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health service is provided.
Prescription Drug Benefits	

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

Preventive Care Services	
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife (with a referral from your Primary Physician). A deductible does not apply.
Additional Preventive Care Services. All FDA approved methods of contraception are covered under this Policy without cost sharing as required by federal and state law.	You pay nothing for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife (with a referral from your Primary Physician). A deductible does not apply.

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 Devices	
	10% co-insurance, after the medical deductible has been met.
Reconstructive Procedures	
	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
Rehabilitation and Habilitative Services- Outpatient Therapy and Manipulative Treatment	
Rehabilitation Services are limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of manipulative treatments. Habilitative Services are limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of manipulative treatments.	$40 co-pay per visit for manipulative treatment (with a referral from your Primary Physician). A deductible does not apply. $20 co-pay per visit (for all other rehabilitation services). A deductible does not apply.
Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)	
Limited to care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered up to 20 visits each for physical, occupational and speech therapy, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	$40 co-pay per visit for manipulative treatment (with a referral from your Primary Physician). A deductible does not apply. $20 co-pay per visit (for all other rehabilitation services). A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office provided by your Primary Physician or Network Obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 10% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office (with a referral from your Primary Physician). 10% co-insurance after you pay the $500 per occurrence deductible per date of service and the medical deductible has been met for services provided at an outpatient hospital-based center provided by your Primary Physician or Network Obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 10% co-insurance after you pay the $500 per occurrence deductible per date of service and the medical deductible has been met for services provided at an outpatient hospital-based center (with a referral from your Primary Physician).
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 100 days per year in a Skilled Nursing Facility.	10% co-insurance, after the medical deductible has been met.
Substance Use Disorder Services	
Inpatient:	10% co-insurance, after the medical deductible has been met.
Outpatient:	$40 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.
Surgery - Outpatient	
	10% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office provided by your Primary Physician or Network Obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 10% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office (with a referral from your Primary Physician). 10% co-insurance after you pay the $500 per occurrence deductible per date of service and the medical deductible has been met for services provided at an outpatient hospital-based surgical center provided by your Primary Physician or Network Obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 10% co-insurance after you pay the $500 per occurrence deductible per date of service and the medical deductible has been met for services provided at an outpatient hospital-based surgical center (with a referral from your Primary Physician).

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Telehealth Services	
	The amount you pay is based on where the covered health service is provided.
Temporomandibular Joint Services	
	The amount you pay is based on where the covered health service is provided.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance, after the medical deductible has been met.
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.
Urgent Care Center Services	
	$75 co-pay per visit. A deductible does not apply.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.	
Virtual Visits	
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.	$10 co-pay per visit. A deductible does not apply.

Common Medical Event	Your cost if you use Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Routine Vision Examination Limited to once every 12 months.	$10 co-pay per visit. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	$25 co-pay. A deductible does not apply.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.
Eyeglass Frames Limited to once every 12 months.	
Eyeglass frames with a retail cost up to $130.	You pay nothing. A deductible does not apply.
Eyeglass frames with a retail cost between $130 - 160.	$15 co-pay. A deductible does not apply.
Eyeglass frames with a retail cost between $160 - 200.	$30 co-pay. A deductible does not apply.
Eyeglass frames with a retail cost between $200 - 250.	$50 co-pay. A deductible does not apply.
Eyeglass frames with a retail cost greater than $250.	40% co-insurance. A deductible does not apply.
Contact Lenses/Necessary Contact Lenses You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	$25 co-pay. A deductible does not apply.
Low Vision Services Limited to a 24 month frequency, or every 6 months when low vision conditions occur.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.
Vision Examination (Benefit is for Covered Persons over age 19)	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Limited to 1 exam every 12 months.	$10 co-pay per visit. A deductible does not apply.

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 Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 7 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 Hospitalization and General Anesthesia for Dental Procedures for Children and Cleft Lip and Cleft Palate Treatment in Section 7 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 7 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; as described under Hospitalization and General Anesthesia for Dental Procedures for Children in Section 7 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. This exclusion does not apply to pediatric dental services for which Benefits are described under Pediatric Dental Services in Section 7 of the COC. 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 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 accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 7 of the COC. This exclusion does not apply to pediatric dental services for which Benefits are described under Pediatric Dental Services in Section 7 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 7 of the COC. This exclusion does not apply to pediatric dental services for which Benefits are described under Pediatric Dental Services in Section 7 of the COC. Dental braces (orthodontics). This exclusion does not apply to pediatric dental services for which Benefits are described under Pediatric Dental Services in Section 7 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to pediatric dental services for which Benefits are described under Pediatric Dental Services in Section 7 of the COC.

Services your plan does not cover (Exclusions)

Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service in Section 7 of the COC and under Pediatric Dental Services in Section 1 of the COC. Dental Services that are not Necessary. Hospitalization or other facility charges except as described under Hospital – Inpatient Stay and Surgery – Outpatient in Section 7 of the COC. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body except as described under Reconstructive Procedures or Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Any Dental Procedure not directly associated with dental disease. Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. 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. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit or as described under Outpatient Prescription Drugs in Section 7 of the COC. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue except as described under Physician Fees for Surgical and Medical Services in Section 7 of the COC. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision except as described under Physician Fees for Surgical and Medical Services in Section 7 of the COC. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint except as described under Temporomandibular Joint Services in Section 7 of the COC. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Policy. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person’s family, including spouse, brother, sister, parent or child. Foreign Services are not covered unless required as an Emergency. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO). Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan except as described under Temporomandibular Joint Services in Section 7 of the COC. Dental Services from a non-Network Dental Provider.

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. The following devices are excluded, even if prescribed by a Physician: Corrective shoes and orthotic devices for podiatric use and arch supports. Dental devices and appliances except as described under Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Experimental and research braces. More than one orthotic device for the same part of the body, except for replacements; spare devices or alternate use devices. Replacement of lost braces or orthotic devices. Repairs, adjustments or replacements of braces and orthotic devices necessitated by misuse. 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 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 7 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse. Replacement of prosthetic devices due to misuse or to replace lost items.

Drugs

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. 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. These above exclusions do not apply to drugs/medications for which Benefits are provided as described under Outpatient Prescription Drugs in Section 7 of the COC.

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 a prescribed drug if: the drug has been approved by the Food and Drug Administration (FDA) as an "investigational new drug for treatment use"; if it is a drug classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; the drug has been approved by the FDA for the treatment of cancer but has not been approved by the FDA for the treatment of the specific type of cancer for which the drug is prescribed if: the drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the U.S. Department of Health and Human Services; and the treatment is for a Covered Health Service. 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 7 of the COC.

Services your plan does not cover (Exclusions)

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 7 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; 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 7 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 7 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 7 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 7 of the COC.

Mental Health, Neurobiological/Autism Spectrum, and 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. Outside of an initial 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 initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. 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 initial 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 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 an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

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).

Services your plan does not cover (Exclusions)

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 15 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 initial breast implant followed mastectomy. See Reconstructive Procedures in Section 7 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 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 condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Rehabilitation services for speech therapy except as described under Rehabilitation Services - Outpatient Therapy in Section 7 of the COC; as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder; therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to 6 are covered, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity; or as described under Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. 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. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations. 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 a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. 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 7 of the COC. In vitro fertilization regardless of the reason for treatment.

Services your plan does not cover (Exclusions)

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 Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic or Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based 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.

Reproduction

All services and supplies related to conception by artificial means except Artificial Insemination for which Benefits are described under Infertility Services in Section 7 of the COC. This exclusion includes but is not limited to the following services and any prescription drugs, donor semen and donor eggs related to such services: in vitro fertilization; ovum transplants; gamete intra fallopian transfer; zygote intra fallopian transfer. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials; long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue; donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. This exclusion does not apply when the Covered Person is the surrogate for which Benefits are available as described under Pregnancy - Maternity Services in Section 7 of the COC. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Fetal reduction surgery.

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 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. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. 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 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.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 7 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. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

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 as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 7 of the COC.

Services your plan does not cover (Exclusions)

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing except as described in Section 7 of the COC. 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 7 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. This exclusion does not apply to the following: Vision Care services for which benefits are provided as described in Pediatric Vision Care Services in Section 7 of the COC; Professional exams and fitting of Medically Necessary contact lenses when a Network Physician or Network Optometrist prescribes them for a specific medical condition. 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. This exclusion does not apply to hearing aids for minor children as described under Hearing Aids for Minor Children in Section 7 of the COC.

Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services in Section 7 of the COC for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as described under Physician Fees for Surgical and Medical Services in Section 7 of the COC. Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Optional Lens Extras not listed in Section 7 of the COC. Missed appointment charges. Applicable sales tax charged on Vision Care Services. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 15 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 7 of the COC and Schedule of Benefits; and not otherwise excluded in Section 8 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 solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption(This exclusion does not apply to treatment for Injuries resulting from a Covered Person's casual or nonprofessional participation in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding); related to judicial or administrative proceedings or orders except for Medically Necessary Mental Health Services regardless of whether the services are voluntary or court-ordered as a result of contact with the criminal justice or juvenile justice system that we determine meet the definition of a Covered Health Service and for which Benefits are otherwise covered under the Policy as described under Mental Health Services in Section 7 of the COC; Medically Necessary Substance Use Disorder Services regardless of whether the treatment voluntary or court-ordered as a result of contact with the criminal justice or legal system, that we determine meet the definition of a Covered Health Service and for which Benefits are otherwise covered under the Policy as described under Substance Use Disorder Services in Section 7 of the COC; 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 7 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. 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 an Out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance, any deductible or other amount owed 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, except as described under Examination of Covered Persons in Section 11 of the COC. 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. Services and supplies solely for the treatment of intractable pain, including but not limited to services provided by a pain management specialist. For purposes of this exclusion, "pain management" means a pain state in which the cause of the pain cannot be removed and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area. Consultation provided by a provider by telephone or facsimile.

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Item#	Rev. Date	
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UnitedHealthcare of Colorado, Inc.

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Colorado

15/35/70/250 Plan 252

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, Tier 3 or Tier 4. 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

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit

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

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 and Preferred Specialty Network**	**Network**
Tier 1	**$15**	**$37.50**
Tier 2	**$35**	**$87.50**
Tier 3	**$70**	**$175**
Tier 4	**$250**	**$625**

* 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.

** For **Non-Preferred Specialty Drugs**, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Copayment and/or 2 times the Preferred Specialty Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.

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UnitedHealthcare of Colorado, Inc.

Other Important Information about your Outpatient Prescription Drug Benefits

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

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 including, but not limited to, Specialty 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 or, for a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Copayment and/or Coinsurance.

You may be required to fill an initial Prescription Drug Product order and obtain two refills 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 through the Internet at www.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, no Benefits will be paid 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.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or your provider's request and there is another drug that is chemically the same available at a lower cost. When you choose the higher cost drug of the two, you will pay the difference between the higher cost drug and the lower cost drug in addition to your Co-payment and/or Co-insurance that applies to the lower cost drug. The Ancillary Charge does not apply to the Out of Pocket Maximum.

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.
- 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. This does not include Prescription Drug Products that have been approved by the U.S. Food and Drug Administration (FDA) for use in the treatment of cancer but have not been approved by the FDA for the treatment of the specific type of cancer for which the drug is prescribed if: The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the U.S. Department of Health and Human Services; and the treatment is for a Covered Health Service.
- 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. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide through other arrangements, workers' compensation insurance for employees, owners, and/or partners.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- 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.
- Certain Prescription Drug Products for smoking cessation that exceed the minimum number of drugs required to be covered under Patient Protection and Affordable Care Act (PPACA) in order to comply with essential health benefits requirements.
- 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 4.)
- 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. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives, over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Service Task Force (USPSTF) when prescribed by a Physician for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 7 of the COC.
- 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 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 prescribed for the treatment of Inherited Enzymatic Disorders as specified in Section 15 of the COC.
- 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.
- 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.
- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.
- Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.
- 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.