UnitedHealthcare®

YOUR BENEFITS

# Benefit Summary

**Pennsylvania - Choice**
**HSA - 15/1300/100% Plan 6KY**

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com**® – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

## PLAN HIGHLIGHTS

| Types of Coverage | Network Benefits |
|---|---|
| **Annual Deductible - Combined Medical and Pharmacy** | |
| Single Coverage Deductible | $1,300 per year |
| Family Coverage Deductible | $2,600 per year |

> No one in the family is eligible for benefits until the family coverage deductible is met.

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| **Out-of-Pocket Maximum - Combined Medical and Pharmacy** | |
| Single Coverage Out-of-Pocket Maximum | $2,500 per year |
| Family Coverage Out-of-Pocket Maximum | $5,000 per year |

> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

> If more than one person in a family is covered under the Policy, the single Out-of-Pocket Maximum stated above does not apply.

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| **Pediatric Vision Care Services Deductible** | |
| Single Coverage Deductible | Vision Care Services are included in Annual Deductible. |
| Family Coverage Deductible | Vision Care Services are included in Annual Deductible. |



**PAWE076KY14**

| Item# | Rev. Date | |
|---|---|---|
| 325-2176 | 0414 | Base/Value HSA/Comb/NonEmb/14825/2011 |

UnitedHealthcare Insurance Company

## Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

## Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid.

## MOST COMMONLY USED BENEFITS

| Types of Coverage | Network Benefits |
|---|---|
| **Physician's Office Services - Sickness and Injury** | |
| Primary Physician Office Visit | 100% after the Deductible has been met and you pay a $15 Copayment per visit. |
| Specialist Physician Office Visit | 100% after the Deductible has been met and you pay a $30 Copayment per visit. |

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

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| **Preventive Care Services** | |
| Covered Health Services include but are not limited to: | |
| Primary Physician Office Visit | 100%, Copayments and Deductibles do not apply. |
| Specialist Physician Office Visit | 100%, Copayments and Deductibles do not apply. |
| Lab, X-Ray or other preventive tests | 100%, Copayments and Deductibles do not apply. |

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

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| **Urgent Care Center Services** | |
| | 100% after the Deductible has been met and you pay a $75 Copayment per visit. |

> In addition to the Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

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| **Emergency Health Services - Outpatient** | |
| | 100% after the Deductible has been met and you pay a $250 Copayment per visit.<br>*Notification is recommended if confined in a non-Network Hospital.* |
| **Hospital - Inpatient Stay** | |
| | 100% after the Deductible has been met and you pay a $750 Copayment per Inpatient Stay. |

| Types of Coverage | Network Benefits |
|---|---|
| **Ambulance Service - Emergency and Non-Emergency** | |
| Ground Ambulance | 100% after Deductible has been met. |
| Air Ambulance | 100% after Deductible has been met. |
| | *Prior Authorization is recommended for non-Emergency Ambulance.* |
| **Congenital Heart Disease (CHD) Surgeries** | |
| | 100% after the Deductible has been met and you pay a $750 Copayment per Inpatient Stay. |
| **Dental Services - Accident Only** | |
| Benefits are limited as follows:<br>$3,000 maximum per year<br>$900 maximum per tooth | 100% after Deductible has been met.<br>*Prior Authorization is recommended.* |
| **Diabetes Services** | |
| Diabetes Self Management and Training<br>Diabetic Eye Examinations/Foot Care | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. |
| Diabetes Self Management Items | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider. |
| **Durable Medical Equipment** | |
| | 100% after Deductible has been met. |
| **Habilitative Services** | |
| | Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary. |
| **Hearing Aids** | |
| Benefits are limited as follows:<br>$2,500 per year and are limited to a single purchase (including repair/ replacement) per hearing impaired ear every three years. | 100% after Deductible has been met. |
| **Home Health Care** | |
| Benefits are limited as follows:<br>60 visits per year | 100% after Deductible has been met.<br>Postnatal Home Health Care Benefits are not subject to payment of the Annual Deductible or any Copayment or Coinsurance. |
| **Hospice Care** | |
| | 100% after Deductible has been met. |

## ADDITIONAL CORE BENEFITS

| Types of Coverage | Network Benefits |
|---|---|
| **Lab, X-Ray and Diagnostics - Outpatient** | |
| For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category. | |
| Lab Testing - Outpatient | 100% after Deductible has been met. |
| X-Ray and Other Diagnostic Testing - Outpatient | 100% after Deductible has been met. |
| **Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient** | |
| | 100% after the Deductible has been met and you pay a $100 Copayment per service. |
| **Ostomy Supplies** | |
| | 100% after Deductible has been met. |
| **Pediatric Vision Services (Benefits covered up to age 19)** | |
| You may access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com. | |
| **Routine Vision Examination**<br>Benefits are limited to once per year. | 100% after the Deductible has been met and you pay a $15 copay. |
| **Eyeglass Lenses**<br>Benefits are limited to once per year. Coverage includes polycarbonate lenses and standard scratch-resistant coating. | 50% after Deductible has been met. |
| **Eyeglass Frames**<br>Benefits are limited to once per year. | |
| Eyeglass frames with a retail cost up to $130. | 50% after Deductible has been met. |
| Eyeglass frames with a retail cost of $130 - 160. | 50% after Deductible has been met. |
| Eyeglass frames with a retail cost of $160 - 200. | 50% after Deductible has been met. |
| Eyeglass frames with a retail cost of $200 - 250. | 50% after Deductible has been met. |
| Eyeglass frames with a retail cost greater than $250. | 50% after Deductible has been met. |
| **Contact Lenses/Necessary Contact Lenses**<br>Benefits are limited to a 12 month supply. Contacts are in lieu of Frames and Lenses. Reference www.myuhcvision.com for a complete list of covered contacts. | 50% after Deductible has been met. |
| **Pharmaceutical Products - Outpatient** | |
| This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home. | 100% after Deductible has been met. |

| Types of Coverage | Network Benefits |
|---|---|
| **Physician Fees for Surgical and Medical Services** | |
| | 100% after Deductible has been met. |
| **Pregnancy - Maternity Services** | |
| | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.<br><br>For services provided in the Physician's Office, a Copayment will only apply to the initial office visit. |
| **Prosthetic Devices** | |
| | 100% after Deductible has been met. |
| **Reconstructive Procedures** | |
| | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. |
| **Rehabilitation Services - Outpatient Therapy and Manipulative Treatment** | |
| Benefits are limited as follows:<br>20 visits of Manipulative Treatments<br>30 visits of physical therapy<br>30 visits of occupational therapy<br>30 visits of speech therapy<br>20 visits of pulmonary rehabilitation<br>36 visits of cardiac rehabilitation<br>30 visits of post-cochlear implant aural therapy | 100% after the Deductible has been met and you pay a $15 Copayment per visit. |
| **Scopic Procedures - Outpatient Diagnostic and Therapeutic** | |
| Diagnostic scopic procedures include, but are not limited to:<br>Colonoscopy<br>Sigmoidoscopy<br>Endoscopy<br>For Preventive Scopic Procedures, refer to the Preventive Care Services category. | 100% after Deductible has been met. |
| **Skilled Nursing Facility / Inpatient Rehabilitation Facility Services** | |
| Benefits are limited as follows:<br>120 days per year in a Skilled Nursing Facility | 100% after the Deductible has been met and you pay a $750 Copayment per Inpatient Stay. |
| **Surgery - Outpatient** | |
| | 100% after the Deductible has been met and you pay a $500 Copayment per date of service. |

**ADDITIONAL CORE BENEFITS**

| Types of Coverage | Network Benefits |
|---|---|
| **Therapeutic Treatments - Outpatient** | |
| Therapeutic treatments include, but are not limited to:<br>Dialysis<br>Intravenous chemotherapy or other intravenous infusion therapy<br>Radiation oncology | 100% after Deductible has been met. |
| **Transplantation Services** | |
| | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.<br>For Network Benefits, services must be received at a Designated Facility.<br>*Prior Authorization is recommended.* |

| Types of Coverage | Network Benefits |
|---|---|
| **Clinical Trials** | |
| Participation in a qualifying clinical trial for the treatment of:<br>Cancer or other life-threatening disease or condition<br>Cardiovascular (cardiac/stroke)<br>Surgical musculoskeletal disorders of the spine, hip and knees | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.<br><br>*Prior Authorization is recommended.* |
| **Dental Anesthesia** | |
| | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. |
| **Medical Foods** | |
| | Depending upon where the Covered Health Service is provided, Benefits will be 100% after Deductible has been met. Or as stated under the Outpatient Prescription Drug Rider. |
| **Mental Health Services** | |
| | Inpatient:<br>100% after the Deductible has been met and you pay a $750 Copayment per Inpatient Stay.<br><br>Outpatient:<br>100% after the Deductible has been met and you pay a $30 Copayment per visit. |
| **Neurobiological Disorders – Autism Spectrum Disorder Services** | |
| | Inpatient:<br>100% after the Deductible has been met and you pay a $750 Copayment per Inpatient Stay.<br><br>Outpatient:<br>100% after the Deductible has been met and you pay a $30 Copayment per visit. |
| **Oral Surgery** | |
| | 100% after Deductible has been met. |
| **Substance Use Disorder Services** | |
| | Inpatient:<br>100% after the Deductible has been met and you pay a $750 Copayment per Inpatient Stay.<br><br>Outpatient:<br>100% after the Deductible has been met and you pay a $30 Copayment per visit. |

## PEDIATRIC DENTAL SERVICES BENEFIT

| Types of Coverage | Network Benefits |
|---|---|
| **Pediatric Dental Services Deductible (Benefits covered up to age 19)** | |
| Single Coverage Deductible | Dental Services Deductible is included in Annual Deductible. |
| Family Coverage Deductible | Dental Services Deductible is included in Annual Deductible. |
| **Preventive Services** | |
| **Dental Prophylaxis (Cleanings)**<br>Benefits are limited to:<br>2 times per 12 months. | 100% after Deductible has been met. |
| **Fluoride Treatments**<br>Benefits are limited to:<br>2 times per 12 months. | 100% after Deductible has been met. |
| **Sealants (Protective Coating)**<br>Benefits are limited to:<br>Once per first or second permanent molar every 36 months. | 100% after Deductible has been met. |
| **Space Maintainers**<br>Benefits are limited to:<br>1 per 60 months. Benefit includes all adjustments within 6 months of installation. | 100% after Deductible has been met. |
| **Diagnostic Services** | |
| **Periodic Oral Evaluation (Check-up Exam)**<br>Benefits are limited to:<br>2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. | 100% after Deductible has been met. |
| **Radiographs**<br>Benefits are limited to:<br>2 series of films per 12 months for Bitewing.<br>1 time per 36 months for Complete/ Panorex. | 100% after Deductible has been met. |

| Types of Coverage | Network Benefits |
|---|---|
| **Basic Dental Services** | |
| **Endodontics (Root Canal Therapy)**<br>Benefits are limited to:<br>1 time per tooth per lifetime. | 80% after Deductible has been met. |
| **General Services (Including Emergency treatment)**<br>Palliative Treatment: Covered as a separate Benefit only if no other service was done during the visit other than X-rays.<br>General Anesthesia: Covered when clinically necessary.<br>Occlusal Guard: Benefits are limited to:<br>1 guard every 12 months and only covered if prescribed to control habitual grinding. | 80% after Deductible has been met. |
| **Oral Surgery (Including Surgical Extractions)** | 80% after Deductible has been met. |
| **Periodontics**<br>Periodontal Surgery: Benefits are limited to:<br>1 quadrant or site per 36 months per surgical area.<br>Scaling and Root Planing: Benefits are limited to:<br>1 time per quadrant per 24 months.<br>Periodontal Maintenance: Benefits are limited to:<br>2 times per 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement. | 80% after Deductible has been met. |
| **Restorations (Amalgam or Anterior Composite)**<br>Multiple restorations on one surface will be treated as one filling. | 80% after Deductible has been met. |
| **Simple Extractions (Simple tooth removal)**<br>Benefits are limited to:<br>1 time per tooth per lifetime. | 80% after Deductible has been met. |

## PEDIATRIC DENTAL SERVICES BENEFIT

| Types of Coverage | Network Benefits |
|---|---|
| **Major Restorative Services** | |
| **Inlays/Onlays/Crowns (Partial to Full Crowns)**<br>Benefits are limited to:<br>1 time per tooth per 60 months. | 50% after Deductible has been met. |
| **Dentures and other removable Prosthetics**<br>(Full denture/partial denture)<br>Benefits are limited to:<br>1 time per 60 months. | 50% after Deductible has been met. |
| **Fixed Partial Dentures (Bridges)**<br>Benefits are limited to:<br>1 time per tooth per 60 months. | 50% after Deductible has been met. |
| **Implants**<br>Benefits are limited to:<br>1 time per tooth per 60 months. | 50% after Deductible has been met. |
| **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% after Deductible has been met.<br><br>*Prior Authorization recommended for orthodontic treatment.* |

## 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 1 of the COC.

### Dental (For Pediatric Dental, see below)

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of 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.

### 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 (except for podiatric appliances for the prevention of complications associated with diabetes) and some types of braces, including over-the-counter orthotic braces. 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 1 of the COC. 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.

### 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; shoe orthotics (except for podiatric appliances for the prevention of complications associated with diabetes); 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. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness, that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee’s level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

## Neurobiological Disorders – Autism Spectrum Disorders

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee’s level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

## 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. However, this exclusion does not apply to nutritional supplements as described under Medical Foods 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).

## Pediatric Dental 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. Dental Services that are not Necessary. Hospitalization or other facility charges. 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. 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. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. 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. 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. 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 Rider to 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 interceptiveorthodontic appliances previously submitted for payment under the plan. Dental Services from a non-Network Dental Provider.

## Pediatric Vision Services

Benefits are not provided under Pediatric Vision Services for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in 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 Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services. Vision Care Services received from a non-Network Vision Care Provider.

## 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.

## Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the 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 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. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorders. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. 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 a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. 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.

## 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.

## 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/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee’s level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

## 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. 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 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.

### 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 when required on a home basis as described in this section. Private Duty Nursing Services in an Inpatient setting remain excluded. In addition, Benefits for Private Duty Nursing exclude the following: Services provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an Inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing. Services once patient or caregiver is trained to perform care safely. Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver. Services that are custodial in nature (Custodial Care). Intermittent care. 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 (For Pediatric Vision, see above)

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. Routine vision examinations, including refractive examinations to determine the need for vision correction.

### 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. 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 Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance 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®

YOUR BENEFITS

# Benefit Summary

## Outpatient Prescription Drug

**Pennsylvania**
**5/30/60 Plan 0033**
**5/100/300**

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 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 Deductible | |
|---|---|
| Individual Deductible | See Medical Benefit Summary |
| Family Deductible | See Medical Benefit Summary |

| Out-of-Pocket Maximum | |
|---|---|
| Individual Out-of-Pocket Maximum | See Medical Benefit Summary |
| Family Out-of-Pocket Maximum | See Medical Benefit Summary |

A deductible and out-of-pocket maximum may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket maximum amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your copayment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the copayments outlined below. If you reach the Out-of-Pocket maximum, you will not be required to pay a copayment.

Benefit Plan Copayment/Coinsurance - The amount you pay.

| Tier Level | Retail<br>Up to 31-day supply | *Mail Order<br>Up to 90-day supply |
|---|---|---|
| | **Network** | **Network** |
| **Tier 1** | **$5** | **$12.50** |
| **Tier 1 Specialty** | **$5** | **Not Covered**** |
| **Tier 2** | **$30** | **$75** |
| **Tier 2 Specialty** | **$100** | **Not Covered**** |
| **Tier 3** | **$60** | **$150** |
| **Tier 3 Specialty** | **$300** | **Not Covered**** |

* 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.

** Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

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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## Other Important Information about your Outpatient Prescription Drug Benefits

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 tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

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

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

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 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, no Benefit will be paid 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.

**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 arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. 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 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 are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or 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. 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 product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria and administered under the direction of a physician.
- 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.
- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

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