



# Benefit Summary

Connecticut - Choice Plus

Traditional with Deductible-25/500/80% Plan TGR Modified

**UHC Gold**

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	Non-Network Benefits
<b>Annual Deductible</b>		
Individual Deductible	\$500 per year	\$1,500 per year
Family Deductible	\$1,000 per year	\$3,000 per year
> Copayments do not accumulate towards the Deductible.		
> All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.		
<b>Out-of-Pocket Maximum</b>		
Individual Out-of-Pocket Maximum	\$4,000 per year	\$5000 per year
Family Out-of-Pocket Maximum	\$8,000 per year	\$10000 per year
> All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.		
> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.		

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents 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.

**CTXG06TGR14 Modified****Item# Rev. Date**

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Base/Value/Sep/Emb/12783/2011

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.
- > When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

## MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Physician's Office Services - Sickness and Injury</b>		
Primary Physician Office Visit	100% after you pay a \$25 Copayment per visit.	60% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a \$25 Copayment per visit.	60% after Deductible has been met.  <i>Prior Authorization is required for Genetic Testing - BRCA.</i>
<b>Preventive Care Services</b>		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100%, Copayments and Deductibles do not apply.	60% after Deductible has been met.
Specialist Physician Office Visit	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.		
<b>Urgent Care Center Services</b>		
	100% after you pay a \$25 Copayment per visit.	60% after Deductible has been met.
<b>Emergency Health Services - Outpatient</b>		
	100% after you pay a \$100 Copayment per visit.	100% after you pay a \$100 Copayment per visit.  <i>Notification is required if confined in a non-Network Hospital.</i>
<b>Hospital - Inpatient Stay</b>		
	80% after Deductible has been met.	60% after Deductible has been met.  <i>Prior Authorization is required.</i>

## ADDITIONAL CORE BENEFITS

## YOUR BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	80% after Deductible has been met.	80% after Network Deductible has been met.
Air Ambulance	80% after Deductible has been met.  <i>Prior Authorization is required for non-Emergency Ambulance.</i>	80% after Network Deductible has been met.  <i>Prior Authorization is required for non-Emergency Ambulance.</i>
Dental Services - Accident Only		
Benefits are limited as follows: \$3,000 maximum per year \$900 maximum per tooth	80% after Deductible has been met.  <i>Prior Authorization is required.</i>	80% after Network Deductible has been met.  <i>Prior Authorization is required.</i>
Diabetes Services		
Diabetes Self Management and Training 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.  <i>Prior Authorization is required for Durable Medical Equipment in excess of \$1,000.</i>	
Durable Medical Equipment		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.  To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	80% after Deductible has been met.	60% after Deductible has been met.  <i>Prior Authorization is required for Durable Medical Equipment in excess of \$1,000.</i>
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 to a single purchase (including repair/replacement) per hearing impaired ear every two years.	80% after Deductible has been met.	60% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 80 visits per year This Benefit is not subject to the Annual Deductible.	80% Deductible does not apply.	75% Deductible does not apply.  <i>Prior Authorization is required.</i>

## ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Hospice Care</b>		
	80% after Deductible has been met.	60% after Deductible has been met. <i>Prior Authorization is required for Inpatient Stay.</i>
<b>Lab, X-Ray and Diagnostics - Outpatient</b>		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	80% Deductible does not apply.	60% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	80% Deductible does not apply.	60% after Deductible has been met.  <i>Prior Authorization is required for sleep studies.</i>
<b>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>		
When copayments apply for CT, PET, and MRI's, Network Benefits are subject to a combined annual maximum copay of \$375.	80% after Deductible has been met.	60% after Deductible has been met.  <i>Prior Authorization is required.</i>
<b>Ostomy Supplies</b>		
	80% after Deductible has been met.	60% after Deductible has been met.
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	80% after Deductible has been met.	60% after Deductible has been met.
<b>Physician Fees for Surgical and Medical Services</b>		
	80% after Deductible has been met.	60% after Deductible has been met.
<b>Pregnancy - Maternity Services</b>		
	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.  For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
<b>Prosthetic Devices</b>		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met.	60% after Deductible has been met.  <i>Prior Authorization is required for Prosthetic Devices in excess of \$1,000.</i>
<b>Reconstructive Procedures</b>		
	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.	<i>Prior Authorization is required.</i>

## ADDITIONAL CORE BENEFITS

## YOUR BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment</b>		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy  Outpatient rehabilitation therapy services limits will not apply when the diagnosis being treated is Autism Spectrum Disorder.	100% after you pay a \$25 Copayment per visit.	60% after Deductible has been met.
		<i>Prior Authorization is required for certain services.</i>
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy  For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible has been met.	60% after Deductible has been met.
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met.	60% after Deductible has been met.
		<i>Prior Authorization is required.</i>
<b>Surgery - Outpatient</b>		
	80% after Deductible has been met.	60% after Deductible has been met.
		<i>Prior Authorization is required for certain services.</i>
<b>Therapeutic Treatments - Outpatient</b>		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	80% after Deductible has been met.	60% after Deductible has been met.
		<i>Prior Authorization is required for certain services.</i>

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Transplantation Services	<p>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.</p> <p><i>Prior Authorization is required.</i></p>	<p><i>Prior Authorization is required.</i></p>

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Bone Marrow Testing</b>		
Human leukocyte antigen testing or histocompatibility locus antigen testing for A, B and DR antigens (testing to determine the compatibility for bone marrow transplants). The bone marrow testing must be performed at a facility certified under the federal Clinical Laboratory Improvement Act and accredited by the American Society for Histocompatibility and Immunogenetics. Enrollees must register for the National Marrow Donor Program when being tested.	80% after Deductible has been met.	60% after Deductible has been met.
		<i>Prior Authorization is required.</i>
<b>Clinical Trials</b>		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees Disabling or life-threatening chronic disease	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.	
	<i>Prior Authorization is required.</i>	<i>Prior Authorization is required.</i>
<b>Craniofacial Disorders</b>		
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this Benefit Summary.	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.	
		<i>Prior Authorization is required.</i>
<b>Dental Services</b>		
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this Benefit Summary.	80% after Deductible has been met.	60% after Deductible has been met.
		<i>Prior Authorization is required.</i>
<b>Early Intervention Services</b>		
	100% Deductible does not apply.	100% Deductible does not apply.

## STATE SPECIFIC BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Infertility</b>		
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this Benefit Summary. Coverage is limited to individuals under the age of 40; Ovulation induction is limited to a lifetime maximum benefit of four cycles; Intrauterine insemination is limited to a lifetime maximum benefit of three cycles; IVF, GIFT, ZIFT or low tubal ovum transfer are limited to a lifetime maximum of two cycles, with not more than two embryo implantations per cycle; IVF, GIFT, ZIFT and low tubal ovum transfer are limited to individuals who have not been able to conceive, produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatments unless their Physician determines that such treatment is likely to be unsuccessful; Covered services must be performed at facilities that conform to the standards of the American Society of Reproductive Medicine or Society of Reproductive Endocrinology and Infertility.	80% after Deductible has been met.	60% after Deductible has been met.
	<i>Prior Authorization is required.</i>	<i>Prior Authorization is required.</i>
<b>Lyme Disease</b>		
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this Benefit Summary. Coverage for Lyme disease treatment including up to thirty days of intravenous antibiotic therapy and/or sixty days of oral antibiotic therapy. Further treatment if recommended by a board certified rheumatologist, infectious disease specialist or neurologist.	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.	
<b>Medical Foods</b>		
Coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the treatment of inherited metabolic diseases and are administered under the direction of a Physician. Coverage must be provided for specialized formula when they are medically necessary for the treatment of a disease or condition and are administered under the direction of a Physician for children up to twelve years of age.	The cost share amount will be based on the appropriate tier to which the Medical Food has been assigned under your Outpatient Prescription Drug coverage.	The cost share amount will be based on the appropriate tier to which the Medical Food has been assigned under your Outpatient Prescription Drug coverage.
		<i>Prior Authorization is required.</i>



Types of Coverage	Network Benefits	Non-Network Benefits
<b>Mental Health Services</b>		
	Depending upon where the Covered Health Service is provided, Benefits for outpatient Mental Health Services will be the same as those stated under Physician's Office Services - Sickness and Injury, and Benefits for inpatient/intermediate Mental Health Services will be the same as those stated under Hospital - Inpatient Stay in this Benefit Summary.	<i>Prior Authorization is required for certain services.</i>
<b>Neurobiological Disorders – Autism Spectrum Disorder Services</b>		
	Depending upon where the Covered Health Service is provided, Benefits for outpatient Neurobiological Services - Autism Spectrum Disorder Services will be the same as those stated under Physician's Office Services - Sickness and Injury, and Benefits for inpatient/intermediate Neurobiological Services - Autism Spectrum Disorder Services will be the same as those stated under Hospital - Inpatient Stay in this Benefit Summary.	<i>Prior Authorization is required for certain services.</i>
<b>Pain Management</b>		
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this Benefit Summary.	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.	
<b>Substance Use Disorder Services</b>		
	Depending upon where the Covered Health Service is provided, Benefits for outpatient Substance Use Disorder Services will be the same as those stated under Physician's Office Services - Sickness and Injury, and Benefits for inpatient/intermediate Substance Use Disorder Services will be the same as those stated under Hospital - Inpatient Stay in this Benefit Summary.	<i>Prior Authorization is required for certain services.</i>
<b>Wigs</b>		
	80% after Deductible has been met.	60% after Deductible has been met.
<b>Wound Care Supplies</b>		
Benefits are limited as follows: Wound care supplies for the treatment of epidermolysis bullosa as described in the COC section 1.	80% after Deductible has been met.	60% after Deductible has been met.
		<i>Prior Authorization is required.</i>

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents 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.

## EXCLUSIONS

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that covered, those which are excluded or limited, and other terms and conditions of coverage.

### Alternative Treatments

Acupressure; acupuncture (this exclusion does not apply to acupressure and acupuncture services for which Benefits are available as described under Pain Management in Section 1 of the COC); aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in Section 1 of the COC.

### Dental

Dental care, except for which is covered in Section 1 of the COC (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 Craniofacial Disorders and 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 Craniofacial Disorders and 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 Craniofacial Disorders and 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 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-esophageal 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 drugs for the treatment of diabetes and 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; shoe inserts and arch supports.

## EXCLUSIONS CONTINUED

### Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters, and Hypodermic needles and syringes. 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 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 as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits are available as described under Neurobiological Disorders - Autism Spectrum Disorder Services above. Relational problems as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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. Relational problems as a 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. 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.

## EXCLUSIONS CONTINUED

### 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, except as described under Medical Foods in Section 1 of the COC. Infant formula, except specialized formulas as described under Medical Foods in Section 1 of the COC, 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).

### 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. The exception to this is the removal of a breast implant which was implanted on or prior to July 1, 1994, without regard to the purpose of such implantation. 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, except as required for hair loss due to chemotherapy as described in Section 1 of the COC.

### 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 Chiropractic 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. 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. 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.

### 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.

## EXCLUSIONS CONTINUED

### Reproduction

Health services and associated expenses for infertility treatments for Covered Persons over age 40, 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. 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. 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. 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.

### Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. 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. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

### Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. 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, civil union, 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. 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.

Your Copayment 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 Drug Deductible - Network and Non-Network**

Individual Deductible	No Deductible
Family Deductible	No Deductible

**Out-of-Pocket Drug Maximum - Network and Non-Network**

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

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	Non-Network	Network
<b>Tier 1</b>	<b>\$5</b>	<b>\$5</b>	<b>\$12.50</b>
<b>Tier 2</b>	<b>\$30</b>	<b>\$30</b>	<b>\$75</b>
<b>Tier 3</b>	<b>\$60</b>	<b>\$60</b>	<b>\$150</b>

\* Only certain Prescription Drug Products are available through mail order; please visit [www.myuhc.com](http://www.myuhc.com) or call Customer Care at the telephone number on the back of your ID card for more information.

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

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

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

## Other Important Information about your Outpatient Prescription Drug Benefits

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

For a single Copayment 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 manufacture's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

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

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

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

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



## 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 (limits do not apply to diabetic insulin/supplies).
- 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. This exclusion does not apply to drugs for the treatment of a disabling or life-threatening chronic disease or cancer that have not been approved by the Federal Food and Drug Administration for that indication, if the drug has been prescribed for a Covered Person who has been diagnosed with a disabling or life-threatening chronic disease or cancer, provided the drug is recognized for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USPDI); (2) The American Medical Association's Drug Evaluations (AMADE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI). This exception does not provide coverage for any experimental or investigational drugs or any drug which the Federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of disabling or life-threatening chronic disease or cancer for which the drug has been prescribed.
- 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 paid under any workers' compensation law or other similar laws, subject to applicable law..
- 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 FDA approved 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 or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes, except for medications prescribed for gender identity reasons. These medications require medical necessity review by us.
- 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 except that infertility coverage is available for Covered Persons under 40 years of age with the following limitations: Prescription Drug Products associated with Ovulation induction is limited to a lifetime maximum of four benefit cycles; Prescription Drug Products associated with Intrauterine insemination is limited to a lifetime maximum benefit of three cycles; Prescription Drug Products associated with IVF, GIFT, ZIFT and low tubal ovum transfer are limited to a lifetime maximum of two cycles with no more than two embryo implantations per cycle; Prescription Drug Products associated with IVF, GIFT, ZIFT and low tubal ovum transfer are limited to individuals who have not been able to conceive, produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatments unless their Physician determines that such treatment is likely to be unsuccessful.
- Prescription Drug Products for smoking cessation unless medically necessary.
- 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. Any Prescription Drug Product that is Therapeutically Equivalent to an over-the-counter drug except when medically necessary.
- 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 except that such review and approval of new Prescription Drug Products and/or new dosage forms will not be required for any drug prescribed to treat a covered indication so long as the drug has been approved by the

## PHARMACY EXCLUSIONS CONTINUED

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United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in a substantially accepted peer-reviewed medical literature. The standard reference compendia are noted above under the Experimental, Investigational or Unproven Services Exclusion.

- 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 for the following products when administered under the direction of a Physician: 1) amino acid modified preparations and low protein medical food products for the treatment of inherited metabolic diseases, as defined by state law; and 2) Specialized Formulas when such Specialized Formulas are medically necessary for the treatment of a disease or condition.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product unless medically necessary. 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, unless medically necessary. 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 marijuana, including medical marijuana.
- Prescription Drug Products not included on Tier 1, Tier 2 or Tier 3 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.



## Addendum to the Medical Benefit Summary

Connecticut – Choice Plus  
Modified Plan - TGR

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

### ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Virtual Visits/Telemedicine		
Virtual Visits are part of your Telehealth Services benefit. Our network of providers has been expanded to include Virtual Network Providers who can also perform Telehealth Services. Find a Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card.	Cost share for Virtual Visits: 100% after you pay a \$25 Copayment per visit. Deductible does not apply. If Telehealth Services are rendered by a non-Designated Virtual Visit Network Provider, cost share will be based on provider type.	Non-Network Benefits for Telehealth services will be based on provider type.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, these documents shall prevail. It is recommended that you review your these documents 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. **The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.**

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