UnitedHealthcare®

Benefit Summary

Connecticut - Choice Plus
Choice Plus Advanced - Plan ABU3 Modified

UHC Silver Plan

What is a benefit summary?

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

What are the benefits of the UnitedHealthcare Choice Plus Direct Plan?

Get more protection with a national network.

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

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

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

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

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

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

Benefits At-A-Glance

What you may pay for network care

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

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$25	$ 2000	You have 10% co-insurance.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

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

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible		
What is a deductible?		
The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$2000 per year	$4000 per year
Medical Deductible - Family	$4000 per year	$8000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$4,000 per year	$16,000 per year
Out-of-Pocket Limit - Family	$8,000 per year	$32,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

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

What is Prior Authorization?

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

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

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services - Emergency and Non-Emergency		
	You pay 10% coinsurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	You pay 10% coinsurance, after the network medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Bone Marrow Testing		
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.	You pay 10% coinsurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.
Craniofacial Disorders		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Dental Services		
	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Accident Only		
Limited to a maximum of $900 per tooth up to a maximum of $3,000 per year.	You pay 10% coinsurance after the medical deductible has been met. Prior Authorization is required.	You pay 10% coinsurance, after the network medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. 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.	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Early Intervention Services		
	You pay nothing. A deductible does not apply.	You pay nothing. A deductible does not apply.
Emergency Health Services - Outpatient		
	$150 co-pay per visit. A deductible does not apply.	$150 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Hearing Aids		
Limited to a single purchase (including repair and replacement) per hearing impaired ear every 2 years.	You pay 10% coinsurance after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Home Health Care		
	Limited to 80 visits per year. 10% coinsurance after the medical deductible has been met.	25% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Hospital - Inpatient Stay		
	Network: $500 co-pay per inpatient stay $2000 annual max	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Infertility		
The limit is based on where the covered health service is provided. 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.	You pay 10% coinsurance, after the medical deductible has been met. Prior Authorization is required.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	10% coinsurance per service for services provided at a free-standing lab, free- standing diagnostic center or in a physician's office. A deductible does not apply. 10% coinsurance per service for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center. A deductible does not apply.	30% co-insurance, after the medical deductible has been met for services provided at a free-standing lab, free-standing diagnostic center or in a physician's office. 30% co-insurance, after the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center. Prior Authorization is required for sleep studies.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
When co-payments apply for CT, PET, and MRI's, Network Benefits are subject to a combined annual maximum copay of $375.	10% coinsurance per service, after the medical deductible has been met for services provided at a free-standing diagnostic center or in a physician's office. 10% coinsurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.	30% co-insurance, after the medical deductible has been met for services provided at a free-standing diagnostic center or in a physician's office. 30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center. Prior Authorization is required.
Lyme Disease		
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.	The amount you pay is based on where the covered health service is provided.	
Medical Foods		
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 amount you pay will be based on your Outpatient Prescription Drug coverage.	The amount you pay will be based on your Outpatient Prescription Drug coverage. Prior Authorization is required.
Mental Health Services		
Inpatient:	$500 per inpatient stay, $2000 annual max	30% co-insurance, after the medical deductible has been met.
Outpatient:	$45 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	$500 per inpatient stay, $2000 annual max.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$45 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Pain Management		
	The amount you pay is based on where the covered health service is provided.	
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	$25 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$45 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		

Your Costs

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

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. 100% for those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control when no other service is provided during the office visit.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every 3 years.	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Rehabilitation and Habilitative Services - Outpatient Therapy and Chiropractic Treatment		
Limited to: 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. 20 visits of chiropractic treatments. Limits will not apply for Outpatient rehabilitation therapy services when the diagnosis being treated is Autism Spectrum Disorder.	$25 co-pay per visit for physical therapy and occupational therapy. A deductible does not apply. $25 co-pay per visit for all other therapy services. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay 10% coinsurance, after the medical deductible has been met for services provided at a free-standing center or in a physician's office. 10% coinsurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.	30% co-insurance, after the medical deductible has been met for services provided at a free-standing center or in a physician's office. 30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	$500 co-pay per Inpatient Stay, $2000 annual max.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Substance Use Disorder Services		
Inpatient:	$500 per inpatient stay, $2000 annual max.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$45 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Surgery - Outpatient		
	You pay 10% coinsurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. 10% coinsurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.	30% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. 30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center. Prior Authorization is required for certain services.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Transplantation Services		
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$75 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
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: $25 co-pay per visit when rendered by a Designated Virtual Visit Network Provider. If Telehealth Services are rendered by a non-Designated Virtual Visit Network Provider, cost share will be based on provider type. A deductible does not apply.	Out-of-Network Benefits for Telehealth services will be based on provider type.
Wigs		
	You pay 10% coinsurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Wound Care Supplies		
Limited to wound care supplies for the treatment of epidermolysis bullosa as described in Section 1 of the COC.	You pay 10% coinsurance after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Services your plan does not cover (Exclusions)

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

Alternative Treatments

Acupressure; acupuncture; (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-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 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

Services your plan does not cover (Exclusions)

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.

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. Treatments for the primary diagnoses of learning disabilities. 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 disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Services your plan does not cover (Exclusions)

Neurobiological Disorders – Autism Spectrum Disorder

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. Intellectual disability 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 disorders and 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 paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

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.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. This exclusion does not apply to services or procedures being rendered as part of gender identity treatment. Services or procedures rendered for the treatment of gender identity are subject to medical necessity review. 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. 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.

Reproduction

Health services and associated expenses for infertility treatments for Covered Persons, 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, unless the reproductive materials are harvested from the covered member. Donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. The reversal of voluntary sterilization.

Services your plan does not cover (Exclusions)

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. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

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

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. 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, unless such treatment is medically necessary and has been ordered by a pain management specialist. 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.

Services your plan does not cover (Exclusions)

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.

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UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

Outpatient Prescription Drug

Connecticut

5/30/60 Plan 0WK

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**
Tier 1	**$5**	**$5**	**$12.50**
Tier 2	**$30**	**$30**	**$75**
Tier 3	**$60**	**$60**	**$150**

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

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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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)l; 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

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.