UnitedHealthcare®

Benefit Summary

Platinum 90 EPO
California - Navigate
Navigate - Plan AKSI

What is a benefit summary?

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

What are the benefits of the UnitedHealthcare Navigate® Plan?

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

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

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

> **You need to get online referrals from your PCP to see a network specialist.**

> **There's no coverage if you go out of network or if you see a network specialist without a referral.** You will be responsible for the entire cost of the service.

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

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/navigate** 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)
$15	You have no individual deductible.	10%

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

UnitedHealthcare 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
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.	
Medical Deductible - Individual	You do not have to pay a medical deductible.
Medical Deductible - Family	You do not have to pay a medical deductible.
Dental - Pediatric Services Deductible - Individual	You do not have to pay a dental deductible.
Dental - Pediatric Services Deductible - Family	You do not have to pay a dental deductible.
Out-of-Pocket Limit	
What is an out-of-pocket limit?	
The most you pay during a calendar 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 and co-insurance (including pharmacy) count towards meeting the out-of-pocket limit.	
Out-of-Pocket Limit - Individual	$4,000 per year
Out-of-Pocket Limit - Family	$8,000 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.

Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.

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
Acupuncture Services	
	$15 co-pay per visit. A deductible does not apply.
Ambulance Services	
Emergency	$150 co-pay per transport. A deductible does not apply.
Non-Emergency	$150 co-pay per transport. A deductible does not apply. Prior Authorization is required for Non-Emergency Ambulance.
Breast Cancer Services	
	The amount you pay is based on where the covered health service is provided.
Clinical Trials	
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries	
	10% co-insurance (with a referral from your Primary Physician). A deductible does not apply.
Dental Anesthesia Services	
Limited to Covered Persons who are one of the following: A child under seven years of age. A person who is developmentally disabled, regardless of age. A person whose health is compromised and for whom general anesthesia is required, regardless of age.	10% co-insurance. A deductible does not apply. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Services (Benefits covered up to age 19)	
Benefits provided by the National Options PPO 20 Network (INO-MAC).	
Dental - Pediatric Preventive Services	
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	You pay nothing. A deductible does not apply.
Fluoride Treatments	You pay nothing. A deductible does not apply.
Sealants (Protective Coating) Limited to once per first or second permanent molar.	You pay nothing. A deductible does not apply.
Space Maintainers	You pay nothing. A deductible does not apply.
Dental - Pediatric Diagnostic Services	
Periodic Oral Evaluation (Check-up Exam) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing. A deductible does not apply.
Radiographs Limited to 2 series of films per 12 months for Bitewing and 1 time per 24 months for Complete/Panorex.	You pay nothing. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Basic Dental Services	
Endodontics (Root Canal Therapy)	20% co-insurance. A deductible does not apply.
General Services (Including Emergency treatment) Palliative Treatment: Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General Anesthesia: Covered when clinically necessary. Occlusal Guard: Limited to 1 guard every 12 months.	20% co-insurance. A deductible does not apply.
Oral Surgery (Including Surgical Extractions)	20% co-insurance. A deductible does not apply.
Periodontics Periodontal Surgery: Limited to 5 quadrants in any 12 months. Scaling and Root Planing: Limited to 5 quadrants per 12 months. Periodontal Maintenance: Limited to 5 quadrant treatments per 12 months. In conjunction with dental prophylaxis, following active and adjunctive periodontal therapy, exclusive of gross debridement.	20% co-insurance. A deductible does not apply.
Restorations (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as one filling.	20% co-insurance. A deductible does not apply.
Simple Extractions (Simple tooth removal)	20% co-insurance. A deductible does not apply.
Dental - Pediatric Major Restorative Services	
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 36 months.	50% co-insurance. A deductible does not apply.
Dentures and other removable Prosthetics (Full denture/partial denture) Limited to 1 time per 36 months.	50% co-insurance. A deductible does not apply.
Fixed Partial Dentures (Bridges) Limited to 5 units of bridgework per arch.	50% co-insurance. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Dental - Pediatric Medically Necessary Orthodontics	
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance. A deductible does not apply. Prior Authorization required for orthodontic treatment.
Dental Services - Accident Only	
	10% co-insurance. A deductible does not apply. Prior Authorization is required.
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 Treatment	
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.	The amount you pay is based on where the covered health service is provided. Benefits for diabetes supplies will be the same as those stated in section 12 of the COC.
Durable Medical Equipment	
	10% co-insurance. A deductible does not apply.
Emergency Health Services - Outpatient	
	$150 co-pay per visit. A deductible does not apply for Facility Fee. You pay nothing for Physician Fee. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Enteral Formula and Amino Acid-Modified Food Products (Medical Foods)	
	10% co-insurance. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Habilitative Services - Outpatient Therapy and Manipulative Treatment	
Habilitative Services are limited to: 24 visits of manipulative treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	$15 co-pay per visit. A deductible does not apply.
Hearing Aids	
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years. This limit does not apply to bone-anchored hearing aids.	10% co-insurance. A deductible does not apply.
Home Health Care	
Limited to 100 visits per year.	10% co-insurance. A deductible does not apply.
Hospice Care	
	You pay nothing. A deductible does not apply.
Hospital - Inpatient Stay	
	10% co-insurance (with a referral from your Primary Physician). A deductible does not apply.
Infertility Services	
Limited to $2,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.	10% co-insurance. A deductible does not apply. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient	
	$20 co-pay per service. A deductible does not apply for Lab Testing - Outpatient. $40 co-pay per service. A deductible does not apply for X-Ray and Other Diagnostic Testing - Outpatient.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	10% co-insurance. A deductible does not apply.
Mastectomy Services	
	The amount you pay is based on where the covered health service is provided.
Mental Health Services	
Inpatient:	10% co-insurance. A deductible does not apply.
Outpatient Office Visits:	$15 co-pay per visit. A deductible does not apply.
All Other Outpatient Treatment:	You pay nothing. A deductible does not apply.
Nicotine Use Benefit	
Benefits for nicotine use medications are provided under the Outpatient Prescription Drug Schedule of Benefits. Tobacco use and tobacco-related disease counseling and interventions and medications required to be provided under the Preventive Care Services benefit by the Patient Protection and Affordable Care Act are not subject to any cost sharing when provided by Network providers.	$15 co-pay per visit. A deductible does not apply.
Obesity Surgery	
Obesity surgery is covered when received at a designated facility. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.	10% co-insurance. A deductible does not apply. Prior Authorization is required.
Off-Label Drug Use and Experimental or Investigational Services	
	The amount you pay is based on where the covered health service is provided.
Orthotic Benefit	
	10% co-insurance. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Osteoporosis Services	
	The amount you pay is based on where the covered health service is provided.
Ostomy and Urological Supplies	
	10% co-insurance. A deductible does not apply.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance. A deductible does not apply.
Phenylketonuria (PKU) Treatment	
	10% co-insurance. A deductible does not apply.
Physician Fees for Surgical and Medical Services	
	10% co-insurance for outpatient (with a referral from your Primary Physician). A deductible does not apply. 10% co-insurance for inpatient (with a referral from your Primary Physician). A deductible does not apply.
Physician's Office Services	
	$15 co-pay per visit for services provided by your Primary Physician, Network obstetrician or gynecologist. A deductible does not apply. $40 co-pay per visit (with a referral from your Primary Physician). A deductible does not apply.

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

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Pregnancy - Maternity Services	
We pay for Covered Health Services incurred if you participate in the Expanded Alpha Feto Protein (AFP) program, a statewide prenatal testing program administered by the State Department of Health Services.	The amount you pay is based on where the covered health service is provided. Prenatal care office visits received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy. The first postnatal/postpartum visit is covered at no charge. The amount you pay for subsequent postnatal/postpartum care is based on where the covered health service is provided.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing for services provided by your Primary Physician, Network obstetrician or gynecologist (with a referral from your Primary Physician). A deductible does not apply.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.	
Prosthetic Devices	
	10% co-insurance. A deductible does not apply.
Reconstructive Procedures	
	The amount you pay is based on where the covered health service is provided.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	
Rehabilitation Services are limited to: 24 visits of manipulative treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	$40 co-pay per visit for manipulative treatment (with a referral from your Primary Physician). A deductible does not apply. $15 co-pay per visit (for all other rehabilitation services). A deductible does not apply.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance for services provided by your Primary Physician, Network obstetrician or gynecologist. A deductible does not apply. 10% co-insurance (with a referral from your Primary Physician). A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services (Including Habilitative Services During an Inpatient Stay)	
Limited to 100 days per benefit period for Skilled Nursing Facility. Inpatient rehabilitation facility services are unlimited. Inpatient habilitative services are unlimited.	10% co-insurance. A deductible does not apply.
Specialized Footwear	
	10% co-insurance. A deductible does not apply.
Substance Use Disorder Services	
Inpatient:	10% co-insurance. A deductible does not apply.
Outpatient Office Visits:	$15 co-pay per visit. A deductible does not apply.
All Other Outpatient Treatment:	You pay nothing. A deductible does not apply.
Surgery - Outpatient	
	10% co-insurance for services provided by your Primary Physician, Network obstetrician or gynecologist. A deductible does not apply. 10% co-insurance (with a referral from your Primary Physician). A deductible does not apply.
Telehealth Services	
	The amount you pay is based on where the covered health service is provided.
Temporomandibular Joint (TMJ) Services	
	The amount you pay is based on where the covered health service is provided.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Transplantation Services	
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Urgent Care Center Services	
	$15 co-pay per visit. A deductible does not apply.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.	
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$15 co-pay per visit. A deductible does not apply.

Common Medical Event	Your cost if you use Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Routine Vision Examination Limited to once every 12 months.	You pay nothing. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	You pay nothing. A deductible does not apply.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.
Eyeglass Frames Limited to once every 12 months.	You pay nothing. A deductible does not apply.
Contact Lenses/Necessary Contact Lenses You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	You pay nothing. A deductible does not apply.
Low Vision Services	
Low Vision Comprehensive Evaluation Limited to once every 24 months.	You pay nothing for Low Vision Comprehensive Evaluation. A deductible does not apply.
Low Vision Follow-up Care Limited to four visits in any 5 year period.	You pay nothing for Low Vision Follow-up Care. A deductible does not apply.
Low vision aid such as high-power spectacles, magnifiers and telescopes. Limited to once every 12 months.	20% co-insurance for Low Vision aid such as high-power spectacles, magnifiers and telescopes. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Vision Examination (Benefit is for Covered Persons over age 19)	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Limited to 1 exam every 12 months.	$15 co-pay per visit. A deductible does not apply.

Services your plan does not cover (Exclusions)

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

Alternative Treatments

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

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to general anesthesia and associated Hospital or Alternate Facility charges for which Benefits are provided as described under Dental Anesthesia Services in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of an acute traumatic health condition, 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. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth. This exclusion does not apply to dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Denials of coverage are subject to Independent Medical Review for Experimental and Investigational Therapies. Dispensing of drugs/medications not normally supplied in a dental office. Replacement of loss or theft of dentures or bridgework. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Certificate. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Dental implants are excluded, but it is considered optional dental treatment. An optional benefit is a dental benefit that you choose to have upgraded. For example when a filling would correct the tooth but you choose to have a full crown instead. If you choose to have an implant rather than a Covered Dental Service such as a denture or fixed bridge, we will pay our cost share of the Covered Dental Service and you will be responsible for the additional cost of the upgrade to a dental implant. Orthodontic treatment unless medically necessary as described under Medically Necessary Orthodontic Services in Section 10 of the COC. Surgical removal of impacted teeth is Covered Dental Service only when evidence of pathology exists. Dental Services from a non-Network Dental Provider.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. 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 prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC and 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.

Services your plan does not cover (Exclusions)

Drugs

Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and is required by California law when prescribed by a Network provider for which Beneifts are available without cost sharing, as described under Preventive Care in Section 1 of the COC. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC. Growth hormone therapy, except when Medically Necessary. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under Section 9: Defined Terms and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a chronic and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the American Hospital Formulary Service's Drug Information; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. 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. Shoes. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Shoe orthotics. This exclusion does not apply to shoes for which Benefits are provided as described under Specialized Footwear in Section 1 of the COC. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC. Arch supports. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Medical Supplies

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

- Lymphedema gradient compression stockings for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC.
- 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 Treatment in Section 1 of the COC.
- Ostomy and urological supplies for which Benefits are provided as described under Ostomy and Urological 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 as mental disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Only Mental Health Services as treatments for R and T code conditions as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association chapters entitled "Medication-Induced Movement Disorders and Other Adverse Effects of Medication" and "Other Conditions That May Be a Focus of Clinical Attention" are excluded. Educational services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Autism Spectrum Disorders, Severe Mental Illness or Serious Emotional Disturbances in Section 9 of the COC. Tuition or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed 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, that are 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

Enteral feedings, even if the sole source of nutrition, except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods), except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers. This exclusion does not apply to batteries for home blood glucose monitors and infusion pumps as described under Diabetes Treatment and Durable Medical Equipment in Section 1 of the COC; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement and as required by California regulation); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. This exclusion does not apply to the surgical or non-surgical treatment of morbid obesity for which Benefits are provided as described under Obesity Surgery in Section 1 of the COC. This exclusion does not apply to services that have in effect the current recommendations of the United States Preventive Services Task Force for obesity screening in children, adolescents and all adults as described under Preventive Care Services in Section 1: of the COC. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations; and physical therapy modalities that have general value but show limited or no efficacy in the treatment of TMJ including cold laser, diathermy, thermography, iontophoresis, biofeedback, and TENS. Upper and lower jawbone surgery except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in Temporomandibular Joint (TMJ) Services under Section 1 of the COC. Orthognathic surgery, and jaw alignment, except as a treatment of obstructive sleep apnea. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under Other Health Education Services for You in the section of the Certificate titled Our Responsibilities. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under Preventive Care Services in Section 1 of the COC. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility. Obesity surgery that is not received at a Designated Facility.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic or Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic or Hospital-based Facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Services your plan does not cover (Exclusions)

Reproduction

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

Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

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 services that are focused solely on primarily building skills and capabilities in communication, social interaction and learning. This exclusion for behavioral services does not apply to conditions defined as Severe Mental Illness and Serious Emotional Disturbances in Section 9 of the COC. 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, that are 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 connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. 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. This exclusion does not apply to Medically Necessary pain management for acute and chronic pain provided during an Inpatient Stay in a Hospital. Custodial care or maintenance care. This exclusion does not apply to Custodial Care or maintenance care for which Benefits are provided under Home Health Care, Hospice Care, Hospital - Inpatient Stay, and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services in Section 1 of the COC. 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. This exclusion does not apply to services for which Benefits are provided under Hospice Care and Home Health Care in Section 1 of the COC. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Services your plan does not cover (Exclusions)

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. This exclusion does not apply to special contact lenses for aniridia and aphakia for which Benefits are provided as described under Vision Examinations in Section 1 of the COC. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). This exclusion does not apply to contact lenses for aniridia (missing iris) and aphakia (absence of crystalline lens of the eye). 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 the Covered Person has either of the following Craniofacial anomalies in which normal or absent ear canals preclude the use of a wearable hearing aid; or Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services for the following: Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following: Medically Necessary. Not otherwise excluded in Section 2 of the COC. 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 the United States or in non-war zones outside of the United States. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an Out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law. 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.

For Internal Use only:
CAWa42AKSI17

Item#	**Rev. Date**	
400-8474	0816_rev01	G14-006/Sep/Emb/26033/2011

UnitedHealthcare Insurance Company

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

California

5/15/25/10% Plan 354

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit

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

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

Tier Level	Retail Up to 31-day supply	*Mail Order Up to 90-day supply
	Network and Preferred Specialty Network**	**Network**
Tier 1	**$5**	**$12.50**
Tier 2	**$15**	**$37.50**
Tier 3	**$25**	**$62.50**
Tier 4	**10% however you will not pay more than $250**	**10% however you will not pay more than $625**

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

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

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.

CAWPAA35417
Item# **Rev. Date**
400-8119 0816
UnitedHealthcare Insurance Company

Other Important Information about your Outpatient Prescription Drug Benefits

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

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

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

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

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

If you require certain Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product or, for a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Copayment and/or Coinsurance.

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

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

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

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

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

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to these services. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay (Benefits for Prescription Drug Products provided during an Inpatient Stay are available as described under Hospital - Inpatient Stay in Section 1of the COC).
- Experimental, Investigational or Unproven Services and medications; medications used for Experimental indications and/or dosage regimens that are Experimental, Investigational or Unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Any product dispensed for the purpose of appetite suppression or weight loss when prescribed solely for the purposes of losing weight. This exclusion does not apply to outpatient prescription drugs prescribed for the Medically Necessary treatment of morbid obesity for which Benefits are provided as described under Obesity Surgery in Section 1of the COC.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins. This exclusion does not apply to vitamins that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) that are required to be covered under the Patient Protection and Affordable Care Act (PPACA).
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that 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.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 4.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. However, this exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter. Certain Prescription Drug Products that are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices, and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1of the COC. This exclusion does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC.
- Any oral non-sedating antihistamine or antihistamine-decongestant combination.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of a health condition, except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC.
- Prescription Drug Products designed to adjust sleep schedule, such as for jet lag or shift work.
- Prescription Drug Products when used for sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

- Medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals. This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in Section 10 Pediatric Dental Services of the COC.
- Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.
- A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.