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 care services, when possible.

What are the benefits of the Optimum Choice 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.

> **You need to select your personal PCP from the plan network.**

> **You need to get referrals to see a network specialist.** Your PCP must submit all referrals.

> **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? 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	Individual Deductible	Co-insurance
(Your cost for an office visit)	**(Your cost before the plan starts to pay)**	**(Your cost share after the deductible)**
$30	$1,500	10%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, 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.

Optimum Choice, Inc.

Your Costs

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

Your cost if you use Network Benefits

Annual Deductible

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care 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 covered health care service.

> 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	$1,500 per year
Medical Deductible - Family	$3,000 per year

Out-of-Pocket Limit

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> 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	$4,500 per year
Out-of-Pocket Limit - Family	$9,000 per year

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). 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 is the amount you incur each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). Any dollar amount Co-payment is payable directly to the provider of the Covered Health Care Service at the time of service. If the provider does not request payment of the Co-payment at the time service is rendered or a supply provided, you need not pay the Co-payment at that time, and the provider will bill you for the Co-payment. You will never be denied Covered Health Care Services because of an inability to meet the Co-payment requirement. You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Precertification/Preadmission Authorization?

Precertification or preadmission authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining precertification or preadmission authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain precertification or preadmission authorization.

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.

Covered Health Care Services	Your cost if you use Network Benefits
Acupuncture Services	
Limited to 12 visits per year.	$60 co-pay per visit. A deductible does not apply.
Ambulance Services	
Emergency Ambulance:	10% co-insurance, after the medical deductible has been met.
Non-Emergency Ambulance:	10% co-insurance, after the medical deductible has been met.
Amino Acid-Based Elemental Formula	
	10% co-insurance, after the medical deductible has been met.
Bones of Face, Neck, and Head	
	10% co-insurance, after the medical deductible has been met.
Cellular and Gene Therapy	
Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Precertification is required.
Child Wellness Services	
	You pay nothing. A deductible does not apply.
Chiropractic Services	
Limited to 20 visits per year.	$30 co-pay per visit. A deductible does not apply.
Clinical Trials	
	The amount you pay is based on where the covered health care service is provided except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.
Congenital Heart Disease (CHD) Surgeries	
	10% co-insurance, after the medical deductible has been met.
Dental Services - Accident Only	
	The amount you pay is based on where the covered health care service is provided.

Covered Health Care Services	Your cost if you use Network Benefits
Dental Services - Adjunctive	
	The amount you pay is based on where the covered health care service is provided, except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to the following Benefits, as described in the COC which are required by Maryland law: Dental treatment for cleft lip/cleft palate, Dental anesthesia and associated Hospital and facility charges in conjunction with dental care for children seven years of age and younger and for extremely uncooperative, fearful or uncommunicative children age 17 or younger.
Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits for diabetes self-management items under this Covered Health Care Service.
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider except that any limit on the amount or duration of Benefits specific to the Durable Medical Equipment (DME), Orthotic and Supplies Benefit category or the Outpatient Prescription Drug Rider does not apply to Benefits for diabetes self-management items under this Covered Health Care Service. Diabetes test strips are not subject to Annual Deductible, Co-insurance or Co-payment.
Durable Medical Equipment (DME), Orthotics and Supplies	
Limited to a single purchase of a type of DME or orthotic every three years or as needed to accommodate growth in children. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. Note: Treatment for lymphedema received in connection with the Lymphedema Services benefit is not subject to any limits.	10% co-insurance, after the medical deductible has been met.
Emergency Health Care Services - Outpatient	
	$250 co-pay per visit. A deductible does not apply.
Gender Dysphoria	
	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Habilitative Services	
	The amount you pay is based on where the covered health care service is provided except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service. $30 co-pay per visit. A deductible does not apply.
Hair Prosthesis	
Limited to $350 per year.	10% co-insurance, after the medical deductible has been met.
Hearing Aids	
Limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	10% co-insurance, after the medical deductible has been met.
Home Health Care	
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not apply to the visits mandated by state law as described under Home Health Care in Section 1 of the COC. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Co-payment/Co-insurance and deductible will not apply to postpartum home visits, as described under Home Health Care in Section 1 of the COC. For the administration of intravenous infusion, you must receive services from a provider we identify.	10% co-insurance, after the medical deductible has been met.
Hospice Care	
	10% co-insurance, after the medical deductible has been met.
Hospital - Inpatient Stay	
	10% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits
Infertility Services	
Infertility Services does not include in vitro fertilization. See the In Vitro Fertilization Benefit category.	10% co-insurance, after the medical deductible has been met.
In Vitro Fertilization	
Limited to three in vitro fertilization attempts per live birth, subject to a maximum benefit of $100,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit includes Benefits for medications associated with in vitro fertilization, as provided under the Outpatient Prescription Drug Rider.	10% co-insurance, after the medical deductible has been met.
Lab, X-Ray and Diagnostic - Outpatient	
Lab Testing - Outpatient:	You pay nothing. A deductible does not apply.
X-Ray and Other Diagnostic Testing - Outpatient:	You pay nothing. A deductible does not apply.
Lymphedema Services	
	The amount you pay is based on where the covered health care service is provided except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.
Major Diagnostic and Imaging - Outpatient	
	10% co-insurance, after the medical deductible has been met.
Medical Foods	
	10% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Mental Health Care and Substance - Related and Addictive Disorders Services	
Inpatient:	10% co-insurance, after the medical deductible has been met.
Outpatient:	$60 co-pay per visit. A deductible does not apply.
Any Co-payment for methadone maintenance treatment will not be greater than 50% of the daily cost for the methadone maintenance treatment.	
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance for Partial Hospitalization/Intensive Outpatient Treatment and all other outpatient services except office visits, after the medical deductible has been met.
Ostomy and Urologic Supplies	
Limited to $2,500 per year. This annual dollar limit does not apply to ostomy supplies.	10% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services	
	10% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury	
	$30 co-pay per visit for a primary care physician office visit. A deductible does not apply. $60 co-pay per visit for a specialist office visit. A deductible does not apply.
Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	

Covered Health Care Services	Your cost if you use Network Benefits
Preventive Care Services	
Physician Office Services, Lab, X-Ray or other preventive tests. Note: Services for Fertility Awareness-Based Methods are not subject to cost share.	You pay nothing. 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	
Limited to a single purchase of each type of prosthetic device every three years or as required to accommodate growth in children. Socket replacements may be considered if the Covered Person has a documented significant change in residual volume or weight. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. This limit does not apply to prosthetic devices for any arm, leg, hand, foot, or eye as required under Maryland insurance law.	10% co-insurance, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health care service is provided except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits for reconstructive breast surgery under this Covered Health Care Service.

Covered Health Care Services	Your cost if you use Network Benefits
Rehabilitation Services - Outpatient Therapy	
Any combination of physical therapy, occupational therapy, and speech therapy is limited to 60 visits or 60 days (whichever is greater) per Sickness or Injury. Limited per year as follows: 20 outpatient visits of pulmonary rehabilitation therapy. 36 outpatient visits of cardiac rehabilitation therapy. 20 outpatient visits of cognitive rehabilitation therapy. 30 outpatient visits of post-cochlear implant aural therapy. Note: Outpatient rehabilitative services received in connection with the Treatment of Cleft Lip or Palate or Both Benefits are not subject to any limit shown above.	$30 co-pay per visit. 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, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 60 days per year.	10% co-insurance, after the medical deductible has been met.
Standard Fertility Preservation Procedures	
	10% co-insurance, after the medical deductible has been met.
Surgery - Outpatient	
	10% co-insurance, after the medical deductible has been met.
Surgical Morbid Obesity Treatment	
	10% co-insurance, after the medical deductible has been met.
Telemedicine Services	
	10% co-insurance, after the medical deductible has been met.
Temporomandibular Disorder (TMD) Services	
	The amount you pay is based on where the covered health care service is provided.

Covered Health Care Services	Your cost if you use Network Benefits
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology. Cost share requirements for orally administered cancer chemotherapy will not be less favorable than the cost share requirements for cancer chemotherapy that is administered intravenously or by injection.	10% co-insurance, after the medical deductible has been met.
Transplantation Services	
Network Benefits must be received from a designated provider.	The amount you pay is based on where the covered health care service is provided.
Treatment of Cleft Lip or Palate or Both	
	10% co-insurance, after the medical deductible has been met.
Urgent Care Center Services	
	$75 co-pay per visit. A deductible does not apply.
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$10 co-pay per visit. A deductible does not apply.

Services your plan generally does NOT cover. 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.

- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

Optimum Choice, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdi nínaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

THIS PAGE INTENTIONALLY LEFT BLANK

OPTIMUM CHOICE, Inc.

A UnitedHealthcare Company

Benefit Summary

Outpatient Prescription Drug Products

Maryland Plan 2V
modifiedStandard Drugs:

20/40/70

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 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 into your account on **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 the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

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.

Tier Level	Up to 31-day supply	Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	***Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy****
Tier 1 Prescription Drug Products	**$20**	**$50**
Tier 2 Prescription Drug Products	**$40**	**$100**
Tier 3 Prescription Drug Products	**$70**	**$175**

In Vitro Fertilization Lifetime Maximum Benefit

The maximum amount we will pay for covered Prescription Drug Products for In Vitro Fertilization during the entire period of time the Covered Person is enrolled for coverage under the Policy. This limit includes Benefits covered under the COC.	$100,000 for Prescription Drug Products for In Vitro Fertilization per Covered Person.

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

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

** You will be charged a retail Co-payment and/or Co-insurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Other Important Information about your Outpatient Prescription Drug Benefits

For Prescription Drug Products at a retail Network Pharmacy, you must incur the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you must incur the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. Your Co-payment and/or Co-insurance will never exceed the retail price of the Prescription Drug Product.

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 based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 30-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. A step therapy requirement may not be imposed if: The step therapy drug has not been approved by the U.S. Food and Drug Administration (FDA) for the medical condition being treated; or The prescribing provider documents and notifies us that a Prescription Drug Product: Was ordered by the prescribing provider for the Covered Person within the past 180 days; and Based on the professional judgment of the prescribing provider, was effective in treating the Covered Person's medical condition. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com® or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician or your pharmacist are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service.

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, no Benefit will be paid for that Prescription Drug Product, except when the Prescription Order or Refill is for an Emergency, or for an unforeseen illness, injury, or condition requiring immediate care.

Certain Preventive Care Medications may be covered. You can get more information by contacting us at myuhc.com® or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Pharmacy supply limits apply. Please contact us at myuhc.com® or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Pharmacy.

PHARMACY EXCLUSIONS

The following exclusions apply. In addition see your Certificate and SBN for additional exclusions and limitations that may apply.

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Please access www.myuhc.com through the Internet or call the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent. Note: We will provide immediate coverage for Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber: The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or The covered Prescription Drug Product on the Prescription Drug List: Has been ineffective in treating a Covered Person's disease or condition: or Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Please access www.myuhc.com through the Internet or call the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent. Note: We will provide immediate coverage for Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber: The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or The covered Prescription Drug Product on the Prescription Drug List: Has been ineffective in treating a Covered Person's disease or condition: or Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.
- 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. However, we will provide immediate coverage for Therapeutically Equivalent alternatives if, in the judgment of the authorized prescriber (as defined in Section 12-101 of the Health Occupation Article of the Maryland Code: The excluded Therapeutically Equivalent alternatives are not therapeutically equivalent to the other covered Prescription Drug Products or The covered Therapeutically Equivalent alternatives on the Prescription Drug List: Has been ineffective in treating a Covered Person's disease or condition: or Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is medically necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.
- Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to the off-label use of a Prescription Drug Product if such Prescription Drug Product is recognized for treatment in any of the standard reference compendia or in the medical literature. Furthermore we shall provide Benefits for Prescription Drug Products that have been approved for sale by the U.S. Food and Drug Administration (FDA) whether or not the FDA has approved the Prescription Drug Product for use in treatment a particular condition, to the extent that the Prescription Drug Products are not paid for by the manufacturer, distributor, or provider of that Prescription Drug Product.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used for cosmetic purposes.
- Prescription Drug Products when prescribed to treat infertility. Notwithstanding this exclusion, if in vitro fertilization is a Covered Health Service under the medical Benefits, Prescription Drug Products associated with this procedure are Covered Health Services.
- Certain Prescription Drug Products for tobacco cessation.
- 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 made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. 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 contraceptives that do not require a prescription. Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card for information on which over-the-counter drugs are not covered under the terms of this exclusion. Note: Notwithstanding this exclusion, we will provide immediate coverage for excluded Prescription Drug Products described above if, in the judgment of the Authorized Prescriber: The over-the-counter drug is not equivalent to the Prescription Drug Product on the Prescription Drug List; or An equivalent over-the-counter drug: Has been ineffective in treating the Covered Person's disease or condition; or has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.

- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury, except as described in Medical Foods and Amino Acid-Based Elemental Formula in Section 1 of the COC.

Optimum Choice, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: **Falls Sie Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí nínaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í bikáígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.