UnitedHealthcare®
A UnitedHealth Group Company

YOUR BENEFITS

Benefit Summary

Michigan - Choice Plus
Balanced 100 - 25/1000/100% Plan 5JL

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

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

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	$1,000 per year	$2,000 per year
Family Deductible	$2,000 per year	$4,000 per year

> Member Copayments do not accumulate towards the Deductible.

> All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	$1,000 per year	$7,000 per year
Family Out-of-Pocket Maximum	$2,000 per year	$14,000 per year

> Member Copayments do not accumulate towards the Out-of-Pocket Maximum.

> All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.

> The Out-of-Pocket Maximum includes the Annual Deductible.

Benefit Plan Coinsurance - The Amount We Pay		
	100% after Deductible has been met.	70% after Deductible has been met.
Maximum Policy Benefit		
The maximum amount we will pay during the entire period of time you are enrolled under the Policy.	Combined Network and Non-Network Maximum of $5,000,000 per Covered Person.	

MIWGK5JL07

Item#	Rev. Date	Benefit Accumulator
320-4528	0909	Calendar Year

UnitedHealthcare Insurance Company

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Information on Benefit Limits

> The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.

> All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.

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

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $25 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a $50 Copayment per visit.	70% after Deductible has been met.

> In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% after you pay a $25 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a $50 Copayment per visit.	70% after Deductible has been met.
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	70% after Deductible has been met.
Urgent Care Center Services		
	100% after you pay a $75 Copayment per visit.	70% after Deductible has been met.

> In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.

Emergency Health Services - Outpatient		
	100% after you pay a $200 Copayment per visit.	100% after you pay a $200 Copayment per visit. *Pre-service Notification is required if results in an Inpatient Stay.*
Hospital - Inpatient Stay		
	100% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required.*

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	100% after Deductible has been met.	100% after Network Deductible has been met.
Air Ambulance	100% after Deductible has been met.	100% after Network Deductible has been met.
	Pre-service Notification is required for Non-Emergency Ambulance.	*Pre-service Notification is required for Non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	100% after Deductible has been met.	70% after Deductible has been met. Benefits are limited to $30,000 per surgery. *Pre-service Notification is required.*
Dental Services - Accident Only		
Benefits are limited as follows: $3,000 maximum per year $900 maximum per tooth	100% after Deductible has been met.	100% after Network Deductible has been met.
	Pre-service Notification is required.	*Pre-service Notification is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.	
		Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of $1,000.
Durable Medical Equipment		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.	100% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required for Durable Medical Equipment in excess of $1,000.*
Home Health Care		
Benefits are limited as follows: 60 visits per year	100% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required.*
Hospice Care		
	100% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required for Inpatient stays.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100% Deductible does not apply.	70% after Deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	100% after Deductible has been met.	70% after Deductible has been met.
Ostomy Supplies		
Benefits are limited as follows: $2,500 per year	100% after Deductible has been met.	70% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	100% after Deductible has been met.	70% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	100% after Deductible has been met.	70% after Deductible has been met.
Pregnancy - Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	*Pre-service Notification is required if the Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Prosthetic Devices		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase of each type of prosthetic device every three years.	100% after Deductible has been met.	70% after Deductible has been met.
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Pre-service Notification is required.*
Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment		
Benefits are limited as follows: 20 visits of chiropractic treatment 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy	100% after you pay a $25 Copayment per visit.	70% after Deductible has been met. *Pre-service Notification is required for certain services.*

Types of Coverage	Network Benefits	Non-Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	100% after Deductible has been met.	70% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	100% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required.*
Surgery - Outpatient		
	100% after Deductible has been met.	70% after Deductible has been met.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	100% after Deductible has been met.	70% after Deductible has been met. *Pre-service Notification is required for certain services.*
Transplantation Services		
	100% after Deductible has been met. For Network Benefits, services must be received at a Designated Facility. *Pre-service Notification is required.*	70% after Deductible has been met. Benefits are limited to $30,000 per Transplant. *Pre-service Notification is required.*
Vision Examinations		
Benefits are limited as follows: 1 exam every 2 years	100% after you pay a $25 Copayment per visit.	70% after Deductible has been met.

STATE MANDATED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Antineoplastic Therapy		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Breast Cancer Diagnostic, Treatment and Rehabilitative Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Pre-service Notification is required.	*Pre-service Notification is required.*
Mental Health and Substance Abuse (MH/SA) Services - Inpatient and Intermediate		
Benefits are limited as follows: 30 days per year This limit does not include intermediate Substance Abuse Services for which Benefits are described below under Additional Benefits Required by Michigan Law, Substance Abuse - Outpatient and Intermediate.	100% after Deductible has been met.	70% after Deductible has been met.
	Prior Authorization is required from the MH/SA Designee.	*Prior Authorization is required from the MH/SA Designee.*
Mental Health and Substance Abuse (MH/SA) Services - Outpatient		
Benefits are limited as follows: 20 visits per year This limit does not include outpatient Substance Abuse Services for which Benefits are described below under Additional Benefits Required By Michigan law, Substance Abuse - Outpatient and Intermediate.	100% after you pay a $50 Copayment per visit.	70% after Deductible has been met.
	Prior Authorization is required from the MH/SA Designee.	*Prior Authorization is required from the MH/SA Designee.*

Types of Coverage	Network Benefits	Non-Network Benefits
Pain-Evaluation and Treatment		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Pediatric Dental Anesthesia		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Pre-service Notification is required.
Substance Abuse Services - Outpatient and Intermediate		
At the time the Policy is issued, Benefits are limited to $3,919 per year. This limit is in addition to the limits stated under Benefits described above under Mental Health and Substance Abuse Services - Inpatient and Intermediate and Mental Health and Substance Abuse Services - Outpatient.	Outpatient 100% after you pay a $50 Copayment per visit. Intermediate 100% after Deductible has been met. *Prior Authorization is required from the MH/SA Designee.*	Outpatient 70% after Deductible has been met. Intermediate 70% after Deductible has been met. *Prior Authorization is required from the MH/SA Designee.*

MEDICAL EXCLUSIONS

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

Alternative Treatments

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

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of cancer or cleft palate. Pediatric dental anesthesia and hospital facility charges for which Benefits are provided as described under Pediatric Dental Anesthesia in Section 1 of the COC. 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 treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophogeal voice prosthetics. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications.This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to insulin for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to FDA-approved antineoplastic drugs for which Benefits are available as described under Antineoplastic Therapy in Section 1 of the COC. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet or subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

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

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health / Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol, Cyclazocine, or their equivalents). Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services, except as provided under Substance Abuse Services - Outpatient and Intermediate in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. 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).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; speech generating devices; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing

breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs.

Providers

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

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. This exclusion does not apply to no-fault auto insurance. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

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

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true: no skilled services are identified; skilled nursing resources are available in the facility; the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. Respite care; rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

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. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy.

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UnitedHealthcare®
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Benefit Summary

Outpatient Prescription Drug

Michigan
10/35/60 Plan 02V

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

Annual Drug Deductible - Network and Non-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

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

Individual Out-of-Pocket Maximum	No Out-of-Pocket Drug Maximum
Family Out-of-Pocket Maximum	No Out-of-Pocket Drug Maximum

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 2	**$35**	**$35**	**$87.50**
Tier 3	**$60**	**$60**	**$150**

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

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

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

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Other Important Information about your Outpatient Prescription Drug Benefits

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

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

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

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate of Coverage 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 notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

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

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate of Coverage apply also to this Rider. In addition, the following exclusions apply:

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to any off-label usage of a Prescription Drug Product if all of the following conditions are met; The drug is approved by the federal Food and Drug Administration (FDA). The drug is prescribed by an allopathic or osteopathic Physician for the treatment of either of the following: A life-threatening condition, so long as the drug is medically necessary to treat that condition and the drug is on the Prescription Drug List or accessible through our Prescription Drug List procedures. A chronic and seriously debilitating condition, so long as the drug is medically necessary to treat that condition and the drug is on the Prescription Drug List or accessible through our Prescription Drug List procedures. The drug has been recognized for the treatment for the condition for which it is prescribed by one of the following: The American Medical Association Drug Evaluations. The American Hospital Formulary Service Drug Information. The United States Pharmacopoeia Dispensing Information, Volume 1, Drug Information for the Health Care Professional. Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective, unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. As used in this exclusion: "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity. "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end-point of clinical intervention is survival. "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the federal Food and Drug Administration (FDA).
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate of Coverage. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a medically necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.
- Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
- 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.