

Benefit Summary

Outpatient Prescription Drug

ASO

Mad River

10/20/35% Plan 0F5 Modified

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug. 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 Customer Care at the telephone number on the back of your ID card.

Annual Drug Deductible

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Maximum

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

This summary of Benefits is intended only to highlight your Benefits for Prescription Drugs and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug expenses. Please refer to the Prescription Drug section of the Summary Plan Description (SPD) 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 Prescription Drug section of the SPD, the Prescription Drug section of SPD shall prevail.

SFXPP0F507

Item# Rev. Date

XXX-XXXX 0908

Tier Level	Retail Up to 31-day supply	*Mail Order Up to 90-day supply
	Network & Non-Network	Network
Tier 1	\$10	\$20
Tier 2	\$20	\$40
Tier 3	35% - \$45 min up to \$60 max	35% - \$90 min up to \$120 max
Diabetic Supplies	20%	20%

* 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.

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 or Pharmaceutical Products for which Benefits are described under the Prescription Drug section of the Summary Plan Description (SPD) are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug or Pharmaceutical Products you are required to use a different Prescription Drug(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 Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug from the Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the SPD apply also to this Prescription Drug section. In addition, the following exclusions apply:

Exclusions

- [Outpatient Prescription Drugs obtained from a non-Network Pharmacy.]
- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- [Prescription Drugs 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 to be experimental, investigational or unproven, unless UnitedHealthcare and the [Employer Legal Name] have agreed to cover.
- Prescription Drugs furnished by the local, state or federal government. Any Prescription Drug 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 Drugs 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 the Summary Plan Description (SPD). [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]
- 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 Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that [Employer Legal Name] determine do not meet the definition of a Covered Health Service.
- [Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.]
- [Prescription Drugs when prescribed to treat infertility.]
- [Prescription Drugs when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]
- Prescription Drugs for smoking cessation.
- [Prescription Drugs not included on Tier-1[,], [or] [Tier-2][,], [or] [Tier-3][,], [or] [Tier-4] of the Prescription Drug List at the time the Prescription Order or Refill is dispensed.]
- [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. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-[2] [3] [4]).] [Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
- New Prescription Drugs and/or new dosage forms until the date they are assigned to a tier by our Prescription Drug List Management Committee.
- [Growth hormone therapy.] [Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]
- [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]
- [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]
- A particular Therapeutic Class or Therapeutic Classes. Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.
- [Prescription Drugs when prescribed as sleep aids.]

PHARMACY EXCLUSIONS

- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.
- A Prescription Drug typically administered by a qualified provider or licensed health professional in an outpatient setting [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception].

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