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 Deductible - Network and Out-of-Network**

- Individual Deductible
  - See Medical Benefit Summary

- Family Deductible
  - See Medical Benefit Summary

**Out-of-Pocket Limit - Network**

- 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.

Out-of-Pocket Limit does not apply to Out-of-Network Charges.

A deductible and out-of-pocket limit may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket limit amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your co-payment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the co-payments outlined below. If you reach the out-of-pocket limit, you will not be required to pay a co-payment.

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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 SBN and Evidence 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 SBN or the Evidence of Coverage, the Outpatient Prescription Drug SBN and Evidence of Coverage shall prevail.
<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Up to 31-day supply</th>
<th>Up to 90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail Network Pharmacy or Preferred Specialty Network Pharmacy</td>
<td>Retail Out-of-Network Pharmacy</td>
</tr>
<tr>
<td>Tier 1 Prescription Drug Products</td>
<td>$7</td>
<td>$7</td>
</tr>
<tr>
<td>Tier 2 Prescription Drug Products</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Tier 3 Prescription Drug Products</td>
<td>$35</td>
<td>$35</td>
</tr>
</tbody>
</table>

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. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

**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

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy’s Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance, the Network Pharmacy’s retail price for the Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or a Network Pharmacy’s retail price for the Prescription Drug Product. See the Co-payments and/or Co-insurance in the Benefit Information table for amounts.

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 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 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. 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, your pharmacist or you 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. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

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 Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network 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 Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

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

The following exclusions and limitations apply. In addition see your Pharmacy SBN and Evidence of Coverage for additional exclusions and limitations that may apply.

Pharmacy Exclusions and Limitations

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product unless Medically Necessary. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product unless Medically Necessary. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- 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.

- Experimental or Investigational medications; medications used for experimental treatments for specific diseases and/or dosage regimens are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4 as seen in the Evidence of Coverage.

- 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.

- 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 prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a provider for which Benefits are available, without cost sharing, as described under Section 5 of the Evidence of Coverage.

- Any product prescription or non-prescription for which the primary use is a source of dietary or nutritional products, nutritional supplements, or dietary management of disease, including vitamins (except prenatal) minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicines and prescription medical food products even when used for the treatment of a health condition, except as described under Phenylketonuria (PKU) Treatment in the Evidence of Coverage. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Network Physician provided that the diet is Medically Necessary. This exclusion does not apply to authorized Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbances of a Child (SED).
UnitedHealthcare Benefits Plan of California 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, UT 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 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, 800-537-7897 (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 other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free 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 number listed on your identification card.

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

XIN LUU Y: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp ngữ ngoại miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thiết bị của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 관심분야 카드에 기재된 무료 지원 전화번호로 문의하시십시오.

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

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

ATANSYON: Si w pеле Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sevis ki gratif pou ede w nan lang pa w. Tanpri rele n mounts gratis ki sou kat idannifikasyon 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), udostępniamy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.