

## Williamson County

### Choice Plus – PPO HIGH Plan

Choice Plus plan gives you the freedom to see any Physician or other health care professional from the Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a Network physician, facility or other health care professional. With a Network physician, you do not have to worry about submission of claim forms.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a Non- Network physician, facility or other health care professional means a higher Deductible and Coinsurance. If you choose to seek care outside the Network, your plan pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, applies to the Non-Network benefits. We recommend that you ask the Non-Network physician or health care professional about their billed charges before you receive care.

#### *Some of the Important Benefits of Your Plan:*

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination<sup>SM</sup> services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Hearing screenings are covered.

# Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. <b>More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan.</b></p> <p>If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail.</p> <p>Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.</p> <p>Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.</p> <p>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.</p> <p><b>*Prior Notification is required for certain services.</b></p> <p><b>Pre-existing condition limitations may apply according to the Summary Plan Description.</b></p>	<p><b>Annual Deductible:</b> \$750 per Covered Person per calendar year, not to exceed \$2,250 for all Covered Persons in a family.</p> <p><b>Out-of-Pocket Maximum:</b> \$2,500 per Covered Person per calendar year, not to exceed \$7,500 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for Covered Health Services will not apply to the Out-of-Pocket Maximum.</p> <p><b>Maximum Plan Benefit:</b> \$5,000,000 per Covered Person (Network and Non-Network combined).</p>	<p><b>Annual Deductible:</b> \$1,500 per Covered Person per calendar year, not to exceed \$4,500 for all Covered Persons in a family.</p> <p><b>Out-of-Pocket Maximum:</b> \$10,000 per Covered Person per calendar year, not to exceed \$30,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for Covered Health Services will not apply to the Out-of-Pocket Maximum.</p> <p><b>Maximum Plan Benefit:</b> \$5,000,000 per Covered Person (Network and Non-Network combined).</p>
<b>1. Ambulance Services - Emergency only</b>	<p>Ground Transportation: 10% of Eligible Expenses after Deductible</p> <p>Air Transportation: 10% of Eligible Expenses after Deductible</p>	Same as Network Benefit
<b>2. Dental Services - Accident only</b>	<p>*10% of Eligible Expenses after Deductible</p> <p>*Prior notification is required before follow-up treatment begins.</p>	<p>*Same as Network Benefit</p> <p>*Prior notification is required before follow-up treatment begins.</p>
<b>3. Durable Medical Equipment</b> 1.) Ordered or provided by a Physician for outpatient use. 2.) Used for medical purposes. 3.) Not consumable or disposable. 4.) Not of use to a person in the absence of a disease or disability.	10% of Eligible Expenses after Deductible	<p>*40% of Eligible Expenses after Deductible</p> <p>*Prior notification is required when the cost is more than \$1,000</p>
<b>4. Emergency Health Services</b>	\$225 per visit	<p>Same as Network Benefit</p> <p>*Notification is required if results in an Inpatient Stay.</p>
<b>5. Home Health Care</b> Network and Non-Network Benefits are limited to \$15,000 per calendar year.	Covered at 100% of Eligible Expenses, no Deductible applies	*40% of Eligible Expenses after Deductible
<b>6. Hospice Care</b> Network and Non-Network Benefits are limited to \$20,000 during the entire period of time a Covered Person is covered under the Plan.	Covered at 100% of Eligible Expenses, no Deductible applies	*40% of Eligible Expenses after Deductible
<b>7. Hospital - Inpatient Stay</b>	10% of Eligible Expenses after Deductible	*40% of Eligible Expenses after Deductible
<b>8. Injections Received in a Physician's Office</b>	<p>PCP:\$25 per visit Specialist: \$40 per visit</p> <p>Childhood immunizations birth to 6 years old: No Copayment</p>	40% of Eligible Expenses after Deductible
Allergy Injections	10% of Eligible Expenses after Deductible	

## YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<b>9. Maternity Services</b>		
Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrician):	\$25 per visit	40% of Eligible Expenses after Deductible
Specialist:	\$40 per visit	*Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
	No Copayment applies to Physician office visits for prenatal care after the first visit.	
Hospital – Inpatient Stay:	10% of Eligible Expenses after Deductible	
Outpatient Diagnostic For Lab and Radiology/X-Ray:	No Copayment	
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine:	10% of Eligible Expenses after Deductible	
Professional Fees for Surgical and Medical Services:	10% of Eligible Expenses after Deductible	
<b>10. Outpatient Surgery, Diagnostic and Therapeutic Services</b>		
Outpatient Surgery	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment	40% of Eligible Expenses after Deductible
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
Outpatient Therapeutic Treatments	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
<b>11. Physician's Office Services (Sickness/Injury)</b>		
	Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrician): \$25 per visit	40% of Eligible Expenses after Deductible. No Benefits for preventive care.
	Specialist: \$40 per visit	
	No Copayment applies when a Physician charge is not assessed.	
<b>12. Preventive Care</b>		
Routine physical examinations, pediatric care/immunizations, vaccinations(TB tests, PKU tests), routine hearing examinations, routine gynecological examinations, routine mammograms, routine prostate exams and associated laboratory and radiology services.	Covered at 100% No Deductible Applies	Not covered
Calendar year maximum of \$400. Once the maximum is met, preventive care benefits are applied to deductible / coinsurance.		
Calendar year maximum does not apply to Preventive Care up to age of 24 months.	Childhood immunizations birth to 6 years old: No Copayment	
<b>13. Professional Fees for Surgical and Medical Services</b>		
	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
<b>14. Prosthetic Devices</b>		
Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible

## YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<b>15. Reconstructive Procedures</b>		
Physicians Office Services Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrician):	\$25 per visit	40 % of Eligible Expenses after Deductible
Specialist:	\$40 per visit	
	No Copayment applies when a Physician charge is not assessed.	
Hospital – Inpatient Stay:	10% of Eligible Expenses after Deductible	
Outpatient Surgery:	10% of Eligible Expenses after Deductible	
Outpatient Diagnostic For Lab and Radiology/X-Ray:	No Copayment	
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine:	10% of Eligible Expenses after Deductible	
Professional Fees for Surgical and Medical Services:	10% of Eligible Expenses after Deductible	
Prosthetic Devices:	10% of Eligible Expenses after Deductible	
<b>16. Rehabilitation Services -Outpatient Therapy</b>		
Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	\$25 per visit	40% of Eligible Expenses after Deductible
<b>17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b>		
Network and Non-Network Benefits are limited to \$15,000 per calendar year.	Covered at 100% of Eligible Expenses, no Deductible applies	*40% of Eligible Expenses after Deductible
<b>18. Transplantation Services</b>		
	*10% of Eligible Expenses after Deductible	*40% of Eligible Expenses after Deductible.
<b>19. Urgent Care Center Services</b>		
	\$40 per visit	40% of Eligible Expenses after Deductible
<b>Additional Benefits</b>		
<b>Hearing Aids</b>		
Lifetime maximum benefit of \$1,500	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
<b>Mammograms</b>		
Preventive care to age 35	See preventive care benefits.	40% of Eligible Expenses after Deductible
Over age 35	Covered at 100% of Eligible Expenses, no Deductible applies (does not apply toward Preventive Benefit limit).	

## YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<b>Diabetes Management Training and Supplies</b>		40% of Eligible Expenses after Deductible
Physicians Office Services Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrician):	\$25 per visit	
Specialist:	\$40 per visit	
	No Copayment applies when a Physician charge is not assessed.	
Hospital – Inpatient Stay:	10% of Eligible Expenses after Deductible	*Contact the Human Resources Department for information regarding the Diabetes Program.
Outpatient Surgery:	10% of Eligible Expenses after Deductible	
Outpatient Diagnostic For Lab and Radiology/X-Ray:	No Copayment	
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine:	10% of Eligible Expenses after Deductible	
Professional Fees for Surgical and Medical Services:	10% of Eligible Expenses after Deductible	
Prosthetic Devices:	10% of Eligible Expenses after Deductible	
<b>Mental Health and Substance Abuse Services – Outpatient</b> Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non- Network Benefits are limited to 30 visits per calendar year. . Dollar limits for lifetime maximums removed per our interpretation of the Mental Health Parity Act.	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
<b>Mental Health and Substance Abuse Services – Inpatient and Intermediate</b> Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non- Network Benefits are limited to 30 days per calendar year. Substance Abuse Treatment limited to 3 series of treatment per lifetime. Dollar limits for lifetime maximums removed per our interpretation of the Mental Health Parity Act.	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
<b>Mental Health Services for Serious Mental Illness - Outpatient</b> Network and Non-Network Benefits are limited to 60 visits per calendar year.	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
<b>Mental Health Services for Serious Mental Illness - Inpatient</b> Network and Non-Network Benefits are limited to 45 days per calendar year.	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
<b>Spinal Treatment</b> Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits are limited to \$1,000 per calendar year.	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible
<b>Radial Keratotomy or Lasik Benefit</b> Lifetime maximum of \$1,500 for Network and Non- Network Benefits.	50% of Eligible Expenses after Deductible	50% of Eligible Expenses after Deductible
<b>Temporomandibular Joint Services</b> Diagnostic and surgical treatment of conditions affecting the temporomandibular joint (TMJ). This includes the jaw and the craniomandibular joint. Coverage is to be provided for medically necessary treatment resulting from: 1.) An accident; 2.) A trauma; 3.) A congenital defect; 4.) A developmental defect; 5.) A Pathology.	10% of Eligible Expenses after Deductible	40% of Eligible Expenses after Deductible

## Exclusions

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

### A. Alternative Treatments

Acupuncture; hypnosis; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

### B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

### C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations) are excluded, except anesthesia and as might otherwise be required for transplant preparation, initiation of immunosuppressives, the direct treatment of acute traumatic injury, cancer, or cleft palate, or dental appliances when part of treatment for documented obstructive sleep apnea. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

### D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

### E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, 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, Investigational or Unproven in the treatment of that particular condition.

### F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debanding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot.

### G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

### H. 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. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of 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. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

### I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, except for PKU.

### J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure.

(Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

### K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

### L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

### M. 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, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness 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.

### N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

### O. 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 transplantation services may be reimbursed at our discretion.

### P. Vision and Hearing

Purchase cost of eye glasses or contact lenses. Fitting charge for eye glasses or contact lenses. Eye exercise therapy.

### Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) 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 Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

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 Plan.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecostasia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment, or oral appliances for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description 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 Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.

# ASO

## *Pharmacy Management Program Choice Plus PPO HIGH and LOW Plans*

The pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 56,000 nationwide) to provide convenient access to medications

While most pharmacies participate in the network, you should check first. Call your pharmacist or visit the online pharmacy service at [www.myuhc.com](http://www.myuhc.com). The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

### Copayment per Prescription Order or Refill

Your Copayment 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. Please access [www.myuhc.com](http://www.myuhc.com) through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment or the Home Delivery Pharmacy's Prescription Drug Cost.

Also note that some Prescription Drug Products require that you notify the Claims Administrator's designee in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

	<b>Retail Network Pharmacy</b> For up to a 31 day supply	<b>Home Delivery Network Pharmacy</b> For up to a 90 day supply	<b>Retail Non-Network Pharmacy</b> For up to a 31 day supply
<b>Tier 1</b>	\$10	\$20	\$10
<b>Tier 2</b>	\$30	\$60	\$30
<b>Tier 3</b>	\$50	\$100	\$50

This Summary Plan Description 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 your outpatient prescription drug expenses. Please refer to your Outpatient Prescription Drug Rider and the Summary Plan Description 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 Summary Plan Description, the Outpatient Prescription Drug Rider and Summary Plan Description prevail. Capitalized terms in the Benefit Summary are defined in the Outpatient Prescription Drug Rider and/or Summary Plan Description.

## Other Important Cost Sharing 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.

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### Annual Drug Deductible

No Annual Drug Deductible

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### Out-of-Pocket Drug Maximum

No Out-of-Pocket Drug Maximum

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## Exclusions

*Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:*

Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility. 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.

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 and other weight loss products.

A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by the Claims Administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. 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 are determined to not be 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.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. A Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug may be excluded. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.

Prescription Drug Products for smoking cessation.

Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.

New Prescription Drug Products and/or new dosage forms until the date they are reviewed by the Prescription Drug List Management Committee.

Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

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