United HealthCare Services, Inc. and Tulane University School of Medicine want to help you take control and make the most of your health care benefits. That’s why we provide convenient services to get your health care questions answered quickly and accurately:

- 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 more.
- 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.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD 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.

### PLAN HIGHLIGHTS

<table>
<thead>
<tr>
<th>Types of Coverage</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$250 per year</td>
<td>$250 per year</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$500 per year</td>
<td>$500 per year</td>
</tr>
<tr>
<td>• Member Copayments do not accumulate towards the Deductible unless otherwise noted within the specific benefit category below.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Out-of-Pocket Maximum</td>
<td>$750 per year</td>
<td>$1,500 per year</td>
</tr>
<tr>
<td>Family Out-of-Pocket Maximum</td>
<td>$1,500 per year</td>
<td>$3,000 per year</td>
</tr>
<tr>
<td>• The Out-of-Pocket Maximum includes the Annual Deductible. Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. Prescription Drug Out-of-Pocket Maximum are included in the Medical Out-of-Pocket Maximum.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Benefit Plan Coinsurance – The Amount the Plan Pays**

- 90% after Deductible has been met
- 80% after Deductible has been met

**Prescription Drug Benefits**

- Prescription drug benefits are shown under separate cover.

**Information on Prior Authorization**

- Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician’s Services category)
- Prior Authorization is required for Equipment in excess of $1,000.

**Information on Benefit Limits**

- The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.
- Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid.
- When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.
- In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services.

### BENEFITS

<table>
<thead>
<tr>
<th>Types of Coverage</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services – Emergency and Non-Emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* 90% after Deductible has been met</td>
<td>90% after Network Deductible has been met</td>
<td></td>
</tr>
<tr>
<td>Dental Services – Accident Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tooth/teeth do not need to be sound and natural.</td>
<td>90% after Deductible has been met</td>
<td>90% after Network Deductible has been met</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits are limited as follows: Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums.</td>
<td>90% after Deductible has been met</td>
<td>** 80% after Deductible has been met</td>
</tr>
<tr>
<td>Emergency Health Services - Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% after you pay a $100 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.</td>
<td>100% after you pay a $100 Copayment per visit</td>
<td></td>
</tr>
<tr>
<td>BENEFITS</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Benefits are limited as follows: Limited to $2,800 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.</td>
<td>90% after Deductible has been met</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Benefits are limited as follows: 60 visits per year.</td>
<td>90% after Deductible has been met</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>90% after Deductible has been met</td>
<td>* 80% after Deductible has been met</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>90% after Deductible has been met</td>
<td>* 80% after Deductible has been met</td>
</tr>
<tr>
<td>Lab. X-Ray and Diagnostics - Outpatient</td>
<td>For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.</td>
<td>100% Deductible does not apply</td>
</tr>
<tr>
<td>Lab. X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</td>
<td>90% after Deductible has been met</td>
<td>80% after Deductible has been met</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Inpatient: 90% after Deductible has been met</td>
<td>* 80% after Deductible has been met for both Inpatient and Outpatient</td>
</tr>
<tr>
<td></td>
<td>Outpatient: 100% after you pay a $15 Copayment per visit</td>
<td></td>
</tr>
<tr>
<td>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</td>
<td>Inpatient: 90% after Deductible has been met</td>
<td>*80% % after Deductible has been met for both Inpatient and Outpatient</td>
</tr>
<tr>
<td></td>
<td>Outpatient: 100% after you pay a $15 copayment per visit</td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical Products - Outpatient</td>
<td>This includes medications administered in an outpatient setting, in the Physician’s Office or in a Covered Person’s home.</td>
<td>90% after Deductible has been met</td>
</tr>
<tr>
<td>Physician Fees for Surgical and Medical Services</td>
<td>90% after Deductible has been met</td>
<td>80% after Deductible has been met</td>
</tr>
<tr>
<td>Physician’s Office Services – Sickness and Injury</td>
<td>Primary Physician Office Visit</td>
<td>100% after you pay a $15 Copayment per visit</td>
</tr>
<tr>
<td></td>
<td>Specialist Physician Office Visit</td>
<td>100% after you pay a $15 Copayment per visit</td>
</tr>
<tr>
<td>In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine, Pharmaceutical Products, Scopic Procedures, Surgery; Therapeutic Treatments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy – Maternity Services</td>
<td>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.</td>
<td>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>Covered Health Services include but are not limited to: Primary Physician Office Visit</td>
<td>100% Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist Physician Office Visit</td>
<td>100% Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Lab. X-Ray or other preventive tests</td>
<td>100% Deductible does not apply.</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.</td>
<td>90% after Deductible has been met</td>
</tr>
<tr>
<td>Reconstructive Procedures</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment</td>
<td>Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy No limits on manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.</td>
<td>100% after you pay a $15 Copayment per visit</td>
</tr>
</tbody>
</table>
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.

90% after Deductible has been met
80% after Deductible has been met

Skilled Nursing Facility / Inpatient Rehabilitation Facility Services
Benefits are Limited as follows:
60 days per year

90% after Deductible has been met
*80% after Deductible has been met

Substance Use Disorder Services
Inpatient – 90% after Deductible has been met
Outpatient – 100% after you pay a $15 Copayment per visit
*80% after Deductible has been met

90% after Deductible has been met
*80% after Deductible has been met

Surgery – Outpatient

90% after Deductible has been met
*80% after Deductible has been met

90% after Deductible has been met
*80% after Deductible has been met

For Network Benefits, services must be received at a Designated Facility.

Urgent Care Center Services
100% after you pay a $55 Copayment per visit
80% after Deductible has been met

> In addition to the Copayment stated in this section, the Copayment/coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures, Surgery, Therapeutic Treatments.

Virtual Visits
100% after you pay a $15 Copayment per visit
Not Covered

Vision Examinations
Benefits are Limited as follows:
1 exam every 2 years
100% after you pay a $15 Copayment per visit
Non-Network Benefits are not available

MEDICAL EXCLUSIONS
It is recommended that you review your SPD 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
Acupuncture, aromatherapy, hypnosis; massage therapy; Rolffing (holistic tissue massage); 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 Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

Aesthetic Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). 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 Plan as described in the SPD. 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. Endodontology, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of oral related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental oral conditions. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. 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 – Accidental Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

Devices, Prosthetics and Braces
Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic devices that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, calf bandages, or any other braces available over-the-counter. The following items are excluded: blood pressure monitor; enuresis alarm; non-wearable external defibrillator; toys, and ultrasonic nebulizers. Devices and components to assist in communication and speech except for speech generating devices and tracheo-oesophageal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross negligence. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Exxon
The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order refill. Self-administered medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Exclusions for Observation of Urgent Service
Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as described in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmaceutical regimens are the only available treatment options for your condition. 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 the SPD.

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 the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nails trimming, cutting, or debarking. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: clearing and removing the foot, 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 foot. Shoes (standard or custom); lift and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies and Equipment
Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; 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 the SPD.
- Diabetes supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.
- Tubing, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deformants, fibers, lubricants, tape, appliance clays, adhesive, adhesive remover or other items that are not specifically identified in the SPD.
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Capable to provide services in the following conditions, which are not included in the SPD: – see the description in the SPD. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; not otherwise excluded in the SPD. Covered Health Services as treatments for R & T code conditions and as treatment for other conditions that may be a focus of clinical attention as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Substance-induced sexual dysfunction disorders, substance-induced sleep disorders, feeding disorders, organic brain disorders, feeding disorders, eating disorders, neurological disorders and other conditions with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paranoid schizophrenia. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. F or all services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and primary communication disorders as defined in the Individuals with Disabilities Education Act. R & T codes: Covered Health Services provided as a part of a team for the primary diagnoses as listed in the SPD. Methadone treatment as maintenance. L.A.A.M. (1-alpha-Acetoxy-Methadone), Cyclozine, or their equivalents. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorders that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unapproved Services.

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetics Services in the SPD. Food of any kind. Food that are not covered include: dietary supplement such as other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat iron deficiency anemia or phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diet), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an inpatient stay; and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as sapphire laser, chemosurgery and other such skin ablation procedures); Skin ablation procedures performed as a treatment for acne; treatment of hair loss; venous vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undetectable, including fat accumulation under the male breast and nipple. Treatment for skin or other treatment to improve the appearance of the skin. Treatment for spider veins; hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was placed as a Cosmetic Treatment. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general weight. Loss weight programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even for morbid obesity. Wigs regardless of reason for loss, except for temporary loss of hair resulting from treatment of a malignancy.

Cosmetic Procedures or Treatments. Procedure or surgery to remove fatty tissue such as panniculitis, submental, subfascial, brachyplasty, tracheal surgery, or mastectomy. Exfoliation or elimination of hanging skin as any part of the body. Examples include: plastic surgery procedures such as abdominoplasty, blepharoplasty, breast lift, breast reduction, necklift, and rhinoplasty procedures for correction of unnatural facial features, and traumatic or aesthetic scarring correction procedures. Example: autologous fat grafting (iliac or abdominal fat) injection. Cosmetic procedures performed by any means, including but not limited to surgery, for correction of primary or secondary effects of aging. Repletion of cosmetic defects or restoration of normal or expected appearance. Procedures or treatments which make permanent cosmetic changes, including but not limited to skin rejuvenation, laser hair removal, skin tightening, wrinkle reduction, and scar treatment procedures.

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. The following infertility treatment-related services: Cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Sperm donation (natural or donor) and cryopreservation of sperm. Oocytes donation (natural or donor) and cryopreservation of oocytes. IUI (intrauterine insemination). Assisted reproductive services (including donor-egg and donor-embryo services). Donor insemination. Surrogate mother, gestational surrogate, or gestational carrier. Assisted reproduction technology services for egg donation.
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 Drugs 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.

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.

### 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**: See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies
- **Family Out-of-Pocket Maximum**: See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Retail Up to 31-day supply</th>
<th>*Mail Order Up to 90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$60</td>
<td>$60</td>
</tr>
</tbody>
</table>

* Only certain Prescription Drugs 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 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 dispensed by a Network Pharmacy.
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 up to the stated supply limit. Some Prescription Drugs are subject to additional supply limits.

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 Drugs require that you obtain prior authorization from us in advance to determine whether the Prescription Drug meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

You may be required to fill an initial Prescription Drug Product order and obtain on refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program each year through the Internet at myuhc.com or by calling Customer Care at the telephone number on your ID card.
Pharmacy Exclusions

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

- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum 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 United HealthCare Services, Inc. and the Tulane University School of Medicine 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.
- 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 or repack of Prescription Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that Tulane University School of Medicine 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.
- Certain Prescription Drugs 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 contain a non-FDA approved bulk chemical. 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 3. 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 or supplement. 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.
- Certain New Prescription Drugs and/or new dosage forms until the date they are reviewed and 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).
- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.

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- 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.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- A Prescription Drug Product that contains marijuana, including medical marijuana.