



**Benefit Summary
 ASO Select Plus**

This document is provided as a sample and does not reflect actual benefits. A customized Benefit Summary or Summary Plan Description (SPD) will be created during implementation of the business.

United HealthCare Services, Inc. and the San Francisco Health Service System 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:

- <https://www.whyuhc.com/sfhss> - 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.
- **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.

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

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	\$250 per year	\$500 per year
Individual Plus 1	\$500 per year	\$1,000 per year
Individual Plus 2 or more	\$750 per year	\$1,500 per year
• Member Pharmacy Copayments do not accumulate towards the Deductible unless otherwise notated within the specific benefit category below.		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$10,950 per year	\$10,950 per year
Family Out-of-Pocket Maximum	Not Applicable	Not Applicable
• 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 is not included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	20% after Deductible has been met.	20% after Deductible has been met.
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. • 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– The Amount the Plan Pays

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	20% after Deductible has been met. <i>Pre-service Notification is required for Non-Emergency Ambulance.</i>	20% after Network Deductible has been met. <i>Pre-service Notification is required for Non-Emergency Ambulance.</i>
Dental Services – Accident Only		
	20% after Deductible has been met.	20% after Network Deductible has been met.
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	20% after Deductible has been met.	20% after Deductible has been met. <i>Pre-service Notification is required for Durable Medical Equipment that costs more than \$1,000.</i>

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BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Emergency Health Services - Outpatient		
	20% after Deductible has been met	<i>20% after deductible has been met. If admitted to a Non-Network hospital from the Emergency Room, notification is required within 2 business days of admission.</i>
Gender Dysphoria		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits.	
	20% after deductible has been met.	<i>20 % after deductible has been met Pre-service Notification is required for certain services.</i>
Hearing Aids		
Benefits are limited as follows: \$2,500 per year per Covered Person and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	20% after Deductible has been met.	20% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: Any Combination of Network and Non-Network is limited to 120 visits.	20% after Deductible has been met.	20% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i>
Hospice Care		
Includes 5 days of Respite Care	20% after Deductible has been met.	20% after Deductible has been met. <i>Pre-service Notification is required for Inpatient Stay.</i>
Hospital – Inpatient Stay		
	20% after deductible has been met	20% after Deductible has been met. <i>Pre-service Notification is required.</i>
Infertility		
Up to six natural (intra-cervical) artificial inseminations, three stimulated (intra-uterine) artificial inseminations, and two courses of gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or in vitro fertilization (IVF) per lifetime, and any related prescription medication treatment.	20% after Deductible has been met for Diagnosis and ART	* 20% after Deductible has been met for Diagnosis and ART
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	20% after Deductible has been met.	20% after Deductible has been met. <i>Pre-service Notification is required for sleep studies.</i>
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	20% after Deductible has been met.	20% after Deductible has been met. <i>Pre-Service Notification required for MRI and MRA.</i>
Mental Health Services		
Inpatient	20% after deductible has been met	20% after Deductible has been met.
Outpatient	20% after deductible has been met	20% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i>

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Neurobiological Disorders - Autism Spectrum Disorders		
Inpatient	20% after deductible has been met	20% after Deductible has been met.
Outpatient	20% after deductible has been met	<i>Pre-service Notification is required for certain services.</i>
Nutritional Counseling		
Benefits are limited as follows: Any combination of Network and Non-Network are limited to 4 visits	20% after deductible has been met	20% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes injectables and other medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	20% after Deductible has been met.	20% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	20% after Deductible has been met.	20% after Deductible has been met.
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	20% after deductible has been met	20% after Deductible has been met. <i>Pre-service Notification is required for certain services</i>
Specialist Physician Office Visit	20% after deductible has been met	20% after Deductible has been met. <i>Pre-service Notification is required for certain services</i>
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.	
	20% after deductible has been met.	<i>Pre-service Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	20% after deductible has been met	20% after deductible has been met.
Specialist Physician Office Visit	20% after deductible has been met	
Lab, X-Ray or other preventive tests	20% after deductible has been met	
Immunizations	100% Deductible does not apply	100% Deductible does not apply
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	20% after Deductible has been met.	20% after Deductible has been met. <i>Pre-service Notification is required for Prosthetic Devices that costs more than \$1,000.</i>
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.	
	20% after deductible has been met	20% after the Deductible has been met. <i>Pre-service Notification is required for certain services.</i>

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows for any combination of Network and Non-Network: -60 visits combined of physical therapy, cognitive therapy, and occupational therapy -60 visits of speech therapy -20 visits of pulmonary therapy -36 visits of cardiac therapy -30 visits of post-cochlear implant aural therapy Chiropractic Services: Any combination of Spinal Treatment is limited to \$1000	20% after deductible has been met 20% after deductible has been met	20% after Deductible has been met. 20% after deductible has been met
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.	20% after Deductible has been met.	20% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i>
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: Any combination of Network and Non-Network are limited to 120 days	20% after deductible has been met	20% after Deductible has been met. <i>Pre-service Notification is required.</i>
Substance Use Disorder Services		
Inpatient outpatient	20% after deductible has been met 20% after deductible has been met	20% after Deductible has been met. 20% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i>
Surgery – Outpatient		
	20% after Deductible has been met.	20% after Deductible has been met. <i>Pre-service Notification is required for certain services.</i>
Transplantation Services		
For Network Benefits, services must be received at a Designated Facility.	20% after deductible has been met <i>Pre-service Notification is required.</i>	Non-Network Benefits are not available.
Urgent Care Center Services		
	20% after deductible has been met	20% after Deductible has been met.

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	20% after Deductible has been met per visit.	Non-Network Benefits are not available.
Vision Examinations		
Benefits are limited as follows: Covers charges for tests and treatments due to illness of injury	20% after deductible has been met	20% after deductible has been met
Weight Loss Benefit There is a lifetime maximum of \$1,000 per Covered Person	20% after deductible has been met	20% after deductible has been met

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
Acupressure; aromatherapy; hypnosis; 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 Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.
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 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. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extractions (including wisdom teeth), restoration and replacement of teeth, medical or surgical treatments of dental conditions, 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 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, 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 as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal 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 neglect. 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.
Drugs
The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug Product 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 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 United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. 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 or Investigational or Unproven Services
Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological 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. Nail trimming, cutting, or debriding. 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: 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. Shoes (standard or custom), lifts 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: <ul style="list-style-type: none"> • 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. • Diabetic 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. Tubings, 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 deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health, Neurobiological/Autism Spectrum, and Substance-Related and Addictive Disorders

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational/behavioral services that are primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents for drug addiction. Transitional Living services.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy.. Food of any kind. Foods that are not covered include: enteral feedings and 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 inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), 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.

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 and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

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 salabrasion, chemoablation and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; 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 intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. 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 motivation. Wigs regardless of the reason for the hair loss, except for temporary loss of hair resulting from treatment of a malignancy.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. 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. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Rehabilitation services for 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 Disorder. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Physiological modalities and procedures that result in simple or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniocervical therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery 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 the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

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 ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. 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.

Reproduction

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. 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 by a doula (labor aide), and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. 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 as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. 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 associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. 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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan 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 Plan 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 Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia.

United HealthCare Services, Inc. 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 the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 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 phone 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, 800-537-7697 (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 phone 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 phone number listed on your identification card.

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

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

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

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon 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)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री फ़ोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ **Khmer (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i. T'áá shqóqdi ninaaltsoos nitl'izí bee nééhozinígíí bine'déqé' t'áá jíík'ehgo béésh bee hane'i biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.



**Benefit Summary
Outpatient Prescription Drug**

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 <https://www.whyuhc.com/sfhss> 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 Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug Product expenses. Please refer to Section 15, *Prescription Drugs* 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 Section 15, *Prescription Drugs* of the SPD, Section 15, *Prescription Drugs* of SPD shall prevail.

Annual Drug Deductible – Network and Non-Network

Individual Deductible No Deductible applies
Family Deductible No Deductible applies

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

Individual Out-of-Pocket Maximum See Medical Benefit Summary
Family Out-of-Pocket Maximum See Medical Benefit Summary

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	Non-Network	Network
Tier 1	\$10	50% of the balance after a \$10 copayment per Prescription Order or Refill for a Tier 1 Prescription Drug Product.	\$20
Tier 2	\$25	50% of the balance after a \$25 per Prescription Order or Refill for a Tier 2 Prescription Drug Product.	\$50
Tier 3	\$50	50% of the balance after a \$50 per Prescription Order or Refill for a Tier 3 Prescription Drug Product.	\$100

* Only certain Prescription Drug Products are available through mail order; please visit <http://whyuhc.com/sfhss> or call Customer Care at the telephone number on the back of your ID card for more information.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered Prescription Drug Product and the lower tiered Prescription Drug Product in addition to your Copayment and/or Coinsurance that applies to the lower tier Prescription Drug Product.

Benefits for Prescription Drug Products for the treatment of infertility are covered at 50%.

Other Important Information about your Outpatient Prescription Drug Benefits

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

In addition to the 31-day retail and 90-day mail service supply limits, some products are subject to additional supply limits based on criteria the United Healthcare has developed. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You may obtain a current list of prescription Drug Products that have been assigned maximum quantity levels for dispensing through the Internet at <http://welcometouhc.com/sfhss> or by calling the telephone number on your ID card. The list is subject to periodic review and modification.

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.

Pharmacy Exclusions

Exclusions from coverage listed in the SPD apply also to this Pharmacy Exclusions section.

Exclusions

- Coverage for Prescription Drug Products 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 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 to be experimental, investigational or unproven, unless UnitedHealthcare Services, Inc. and the San Francisco Health Service System have agreed to cover.
- 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 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 of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the San Francisco Health Service System determines 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.
- Compounded Prescription Drug Products 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 bulk powders. 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 the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product, or an over-the-counter drug and/or treatment for female contraception, 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 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 Product that was previously excluded under this provision.
- Certain New Prescription Drug Products 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 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.
- A Prescription Drug Product 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.