



## Benefit Summary Outpatient Prescription Drug

### ZOLL Medical Corporation Pharmacy Plan PPO Plan

*This document is provided as a sample and does not reflect actual benefits. A customized Benefit Summary will be created during implementation of the business.*

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](http://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

Individual Deductible	No Deductible
Family Deductible	No Deductible

#### Out-of-Pocket Drug Maximum

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
	<b>Network</b>	<b>Network</b>
Tier 1	\$10	\$20
Tier 2	\$30	\$60
Tier 3	\$45	\$90

\* Only certain Prescription Drugs are available through mail order; please visit [www.myuhc.com](http://www.myuhc.com) 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 is dispensed at your [or your provider's] 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 drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

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## Other Important Information about your Outpatient Prescription Drug Benefits

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: (i) The applicable Co-payment and/or Co-insurance. (ii) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. (iii) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Product from a mail order Network Pharmacy, you are responsible for paying the lower of: (i) The applicable Co-payment and/or Co-insurance. (ii) The Prescription Drug Charge for that particular Prescription Drug Product.

Also note that some Prescription Drugs require that you notify us in advance to determine whether the Prescription Drug 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 Prescription Drug section. In addition, the following exclusions apply:

### Exclusions

- 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 Prescription Drug Product for which 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.
- Pharmaceutical Products for which Benefits are provided in the medical portion of the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated 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 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 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.
- Prescription Drug Products not included on Tier 3 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a specialist physician.
- Certain New Prescription Drug Products until they are reviewed and assigned to a tier by the PDL Management Committee.
- Prescribed, dispensed or intended for use during an Inpatient Stay.
- Prescribed, dispensed for appetite suppression, and other weight loss products.
- Prescribed to treat infertility.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and ZOLL Medical Corporation determines do not meet the definition of a Covered Health Service.
- Prescription Drug Products that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- Prescription Drug Products that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.
- Unit dose packaging or repackagers of Prescription Drug Products.
- 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.)
- Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and ZOLL Medical Corporation have agreed to cover an Experimental or Investigational or Unproven treatment as defined in the SPD.
- Used for cosmetic purposes.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- General vitamins, except for the following which require a Prescription Order or Refill: Prenatal vitamins, Vitamins with fluoride, single entity vitamins.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.
- A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

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](mailto: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.

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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 benefisye 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. لطفاً 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)** សេវាជំនួយភាសាសម្រាប់អ្នកដែលមានសំណើអ្នក។ សូមទូរស័ព្ទទៅលេខកំណត់ត្រា ដែលមាននៅលើស្លាកសម្គាលាប័ណ្ណសម្រាប់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. 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 shqódi ninaaltsoos nítł'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béesh bee hane'í biká'ígíí bee hodíilnih.

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.