

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

Pharmacy Schedule of Benefits

Summary of Benefits	Generic (Tier 1)	Brand Formulary (Tier 2)	Non-Formulary (Tier 3)
Retail Pharmacy Co-payment (per Prescription Unit or up to 30 days) A 12-month supply at \$0 cost may be provided for FDA-approved, self-administered hormonal contraceptives.	\$15	\$30	\$45
Mail Service Pharmacy Co-payment (three Prescription Units or up to a 90 day supply) A 12-month supply at \$0 cost may be provided for FDA-approved, self-administered hormonal contraceptives.	\$30	\$60	\$90

This Schedule of Benefits provides specific details about your prescription drug benefit, as well as the exclusions and limitations. Together this document and the Supplement to the Combined Evidence of Coverage and Disclosure Form as well as the medical Combined Evidence of Coverage and Disclosure Form determine the exact terms and conditions of your prescription drug coverage.

When tier status changes occur, you may pay more or less for a prescription drug depending on the tier placement. You may access Formulary, Non-Formulary, tier placement and Co-payments by calling Customer Service Department 1-800-624-8822 or 711 (TTY) or visiting UnitedHealthcare’s Web site at www.myuhc.com.

You will receive a written notice 60 days prior to an increase in your Co-payment due to the change in tier placement to move to a higher tier. The notice will inform you of the new tier.

What do I pay when I fill a prescription?

For Prescription Drug Products at a retail pharmacy, you will pay the applicable Co-payment for a Prescription Unit or its retail cost, whichever is less. For Prescription Drug Products from Mail Order, you are responsible for paying the lower of either the applicable Co-payment or the prescription drug cost for that Prescription Drug Product.

You will pay only a Co-payment when filling a prescription at a UnitedHealthcare Participating Pharmacy. You will pay a Co-payment every time a prescription is filled. Your Co-payments are as shown in the grid above.

NOTE: The tier status of a prescription drug can change periodically. Tier status changes resulting in higher Co-payments occur twice per Contract or Plan Year. We will notify you 60 days prior to the change in tiers that will result in a higher co-payment.

Tier changes resulting in lower Co-payments may occur at any time but no more frequent than quarterly.

If A Brand-Name Drug Becomes Available as a Generic

If a generic drug becomes available for a brand name drug, your brand name drug's tier placement may change, and therefore your co-payment may change.

Prior authorization

Select Tier 1, Tier 2 and Tier 3 drugs and Non-Formulary drugs require a Member to go through a Prior authorization process using criteria based upon U.S. Food and Drug (FDA) approved indications or medical findings, and the current availability of the medication. UnitedHealthcare reviews requests for these selected medications to ensure that they are Medically Necessary, being prescribed according to treatment guidelines consistent with standard

Questions? Call the Customer Service Department at 1-800-624-8822.

professional practice and are not otherwise excluded from coverage.

Because UnitedHealthcare offers a comprehensive Formulary, selected non-Formulary medications will not be covered until one or more Formulary alternatives have been tried. UnitedHealthcare understands that situations arise when it may be Medically Necessary for you to receive a certain medication without trying an alternative drug first. In these instances, your Participating Physicians will need to provide evidence to UnitedHealthcare in the form of documents, lab results, records or clinical trials that establish the use of the requested medications as Medically Necessary.

For a list of the selected medications that require UnitedHealthcare's Prior authorization, please contact UnitedHealthcare's Customer Service department at 1-800-624-8822 or 711 (TTY) or view online at www.myuhc.com.

Medication Covered by Your Benefit

When prescribed by your Participating Physician as Medically Necessary and filled at a Participating Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable all-in-one pre-filled insulin pens,** insulin cartridges and needles for non-disposable pens devices are covered when Medically Necessary in accordance with UnitedHealthcare's Prior authorization process.
- **Federal Legend Drugs:** Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs:** Comparable generic drugs may be substituted for brand-name drugs. For brand-name drugs that have FDA approved equivalents, a prescription may be filled with a generic drug unless a specific brand-name drug is Medically Necessary and Prior authorized by UnitedHealthcare, or is on UnitedHealthcare's Selected Brands List. Prior authorization is necessary even if your Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department and may be found on UnitedHealthcare's website at www.myuhc.com. If you choose to use a medication not included on the Formulary and not Prior authorized by UnitedHealthcare, you will be responsible for the full retail price of the medication. You will not pay a rate higher than UnitedHealthcare's contracted rate for the brand-name drug. If the brand-name drug with the generic equivalent is Medically Necessary, it may be Prior Authorized by UnitedHealthcare. If it is

approved, you will only pay your brand-name Co-pay.

- **Miscellaneous Prescription Drug Coverage:** For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to EpiPen[®], Ana-Kits[®], and Ana-Guard[®]). See the medical Combined Evidence of Coverage and Disclosure Form for coverage of other injectable medication and equipment for the treatment of asthma in Section Five under "Your Medical Benefits".
- **Oral Contraceptives:** All FDA-approved contraceptives, drugs, devices, and products are covered at \$0 cost sharing subject to therapeutic equivalents that may be prescribed and may be subject to prior authorization. A Member may receive a 12-month supply of an FDA-approved, self-administered hormonal contraceptive dispensed or furnished at one time by a provider or from a contracted pharmacy that has agreed to dispense or furnish FDA-approved contraceptives in accordance with state and federal law. To determine whether the Plan's contracted pharmacy provides for a pharmacist to dispense FDA-approved contraceptives directly, please contact the contracted pharmacy or call the Plan at the number shown on your card. Please refer to the medical combined Evidence of Coverage and to your Outpatient Prescription Drug Supplement for more information.
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only according to State law.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some that are not covered or limited. These drugs are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form entitled "Your Medical Benefits" for more information about medications covered by your medical benefit.

- **Administered drugs:** Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff is not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled

“Your Medical Benefits” for more information about medications covered under your medical benefit.

- **Compounded medication:** Any Medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Prior authorized as Medically Necessary by UnitedHealthcare.
- **Diagnostic drugs:** Drugs used for diagnostic purposes are not covered. Refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form for information about medications covered for diagnostic tests, services and treatment.
- **Dietary or nutritional** products and food supplements, whether prescription or non-prescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Participating Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form.
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Drugs prescribed solely to treat hair loss.**
- **Enhancement medications** when prescribed for the following non-medical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac[®], Retin-A[®], Renova[®], Vaniqa[®], Propecia[®], Lustra[®], Xenical[®], or Meridia[®]. This exclusion does not exclude coverage for drugs when Prior authorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including but not limited to, Alzheimer’s dementia.
- **Infertility:** All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your employer has purchased coverage for infertility treatment, prescription medications for the treatment of infertility may be covered under that benefit. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form entitled “Your Medical Benefits” for additional information.
- **Injectable medications:** Except as described under the section “Medications Covered By Your

Benefit”, injectable medications including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical Combined Evidence of Coverage and Disclosure Form. Outpatient injectable medications administered in the Physician’s office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare’s Prior authorization requirements. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form under “Your Medical Benefits”.

- **Inpatient medications:** Medications administered to a Member while an inpatient in a hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this Pharmacy Schedule of Benefits. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form entitled “Your Medical Benefits” for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Participating Pharmacy in accordance with all the terms and conditions of coverage set forth in this Schedule of Benefits and in the Pharmacy Supplement to the Combined Evidence of Coverage and Disclosure Form. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Participating Physician at a Participating Pharmacy, and pay the applicable Co-payment on behalf of the Member.
- **Investigational or Experimental drugs:** Medication prescribed for Experimental or Investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section Five, “Your Medical Benefits” and Section Eight, “Overseeing Your Health Care” for appeal rights.
- **Medications dispensed by a Non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.

- **Medications prescribed by Non-Participating Physicians** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **New medications that have not been reviewed for safety, efficacy and cost effectiveness and approved** by UnitedHealthcare are not covered unless Prior authorized by UnitedHealthcare as Medically Necessary.
- **Non-covered medical condition:** Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications directly related to non-covered services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- **Off-label drug use.** Off-label drug use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. UnitedHealthcare excludes coverage for Off Label Drug Use, including off label self-injectable drugs, except as described in the medical Combined Evidence of Coverage and Disclosure Form and any applicable Attachments. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) The American Hospital Formulary Service Drug Information, (b) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapy regimen; (i) The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics Compendium; (iii) The Thompson *Micromedex DRUGDEX System*, or (c) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in major peer-reviewed medical journal. Nothing in this section shall prohibit UnitedHealthcare from use of a Formulary, Co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the Independent Medical Review System as defined in the medical Combined Evidence of Coverage and Disclosure Form.
- **Over-the-Counter Drugs:** There is an exclusion of Over the Counter Drugs whether prescribed or not unless they are on UnitedHealthcare's formulary or unless they are FDA-approved tobacco cessation drugs and products, or FDA-approved contraceptives, drugs, devices or other products both of which are provided as preventive benefit at \$0 cost sharing subject to certain exception. For more information regarding coverage of certain over the counter drugs on the formulary, please see your Outpatient Prescription Drug Supplement and your Combined Evidence of Coverage under Family Planning and Tobacco Screenings. You may also contact UnitedHealthcare's Customer Service Department at 1-800-624-8822 or 711(TTY) or view online at **www.myuhc.com**. Additionally, FDA-approved over-the-counter smoking cessation drugs prescribed by your Physician and female contraceptive methods are covered as preventive. For information regarding coverage of certain over the counter drugs including those on the formulary please contact UnitedHealthcare's Customer Service Department at 1-800-624-8822 or 711 (TTY) or view online at **www.myuhc.com**. Prescription Drug Products that are comprised of identical active ingredients and dosage that are available over-the-counter are not covered except when Medically Necessary. This exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter.
- **Prior to Effective Date:** Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination are not covered.
- **Replacement** of lost, stolen, or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to your medical Combined Evidence of Coverage and Disclosure Form Section Five for additional information.
- **Sexual dysfunction medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to erectile dysfunction, impotence, anorgasmia or hypogasmia, are not covered. An example of such medications includes Viagra®.
- **Smoking cessation products** unless they are FDA-approved tobacco cessation drugs and products, both of which are provided as a

preventive benefit at \$0 cost sharing subject to certain exception. For information on UnitedHealthcare's smoking cessation program, refer to the medical Combined Evidence of Coverage and Disclosure Form in Section Five, "Your Medical Benefits, in the section entitled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our web site at www.myuhc.com.

- **Therapeutic devices or appliances** including, but not limited to, support garments and other non-medical substances, insulin pumps and related supplies (these services are provided as durable medical equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical Combined Evidence of Coverage and Disclosure Form in Section Five, entitled "Your

Medical Benefits" under "Outpatient Benefits" located, for example, in subsections entitled "Diabetic Self Management", "Durable Medical Equipment", or "Home Health Care and Prosthetics and Corrective Appliances".

- **Worker's Compensation:** Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about Workers Compensation can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section Six under "Payment Responsibility".

UnitedHealthcare reserves the right to expand the Prior authorization requirement for any drug product.

Questions? Call the HMO Customer Service department at 1-800-624-8822 or 711 (TTY).

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