


**Benefit Summary  
ASO Choice Plus**

Florida Municipal Insurance Trust HSA Family Medical Plan 5

United HealthCare Services, Inc. and Florida Municipal Insurance Trust 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**<sup>®</sup> - 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
<b>Annual Deductible – Combined Medical and Pharmacy</b>		
Individual Deductible	\$2,600 per year	\$2,500 per year
Family Deductible	\$2,600 per year	\$5,000 per year
<b>Out-of-Pocket Maximum – Combined Medical and Pharmacy</b>		
Individual Out-of-Pocket Maximum	\$3,750 per year	\$7,500 per year
Family Out-of-Pocket Maximum	\$7,500 per year	\$15,000 per year
<ul style="list-style-type: none"> <li>• The Out-of-Pocket Maximum includes the Annual Deductible.</li> <li>• Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.</li> <li>• Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.</li> </ul>		
<b>Benefit Plan Coinsurance – The Amount the Plan Pays</b>		
	90% after Deductible has been met	70% after Deductible has been met
<b>Prescription Drug Benefits</b>		
<ul style="list-style-type: none"> <li>• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.</li> </ul>		
<b>Information of Pre-service Notification</b>		
<i>*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)</i> <i>**Prior Authorization is required for Equipment in excess of \$1,000.</i>		
<b>Information on Benefit Limits</b>		
<ul style="list-style-type: none"> <li>• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.</li> <li>• Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid.</li> <li>• When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.</li> </ul>		

**BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Ambulance Services – Emergency and Non-Emergency</b>		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
<b>Dental Services – Accident Only</b>		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
<b>Durable Medical Equipment (DME)</b>		
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.	90% after Deductible has been met	** 70% after Deductible has been met
<b>Emergency Health Services - Outpatient</b>		
	90% after Deductible has been met	* 90% after Network Deductible has been met

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<b>BENEFITS</b>		
Types of Coverage	Network Benefits	Non-Network Benefits
<b>Hearing Aids</b>		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	90% after Deductible has been met	70% after Deductible has been met
<b>Home Health Care</b>		
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met	* 70% after Deductible has been met
<b>Hospice Care</b>		
	90% after Deductible has been met	* 70% after Deductible has been met
<b>Hospital – Inpatient Stay</b>		
	90% after Deductible has been met	* 70% after Deductible has been met
<b>Lab, X-Ray and Diagnostics - Outpatient</b>		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90% after Deductible has been met	* 70% after Deductible has been met
<b>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>		
	90% after Deductible has been met	70% after Deductible has been met
<b>Mental Health Services</b>		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</b>		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	90% after Deductible has been met	70% after Deductible has been met
<b>Physician Fees for Surgical and Medical Services</b>		
	90% after Deductible has been met	70% after Deductible has been met
<b>Physician's Office Services – Sickness and Injury</b>		
Primary Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
<b>Pregnancy – Maternity Services</b>		
	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.	
		<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
<b>Preventive Care Services</b>		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
<b>Prosthetic Devices</b>		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	90% after Deductible has been met	** 70% after Deductible has been met
<b>Reconstructive Procedures</b>		
	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.	
		<i>Prior Authorization is required.</i>
<b>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment</b>		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of 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.	90% after Deductible has been met	* 70% after Deductible has been met
<b>Scopic Procedures – Outpatient Diagnostic and Therapeutic</b>		
Diagnostic scopic procedures include, but are not limited	90% after Deductible has been met	70% after Deductible has been met

BENEFITS		
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to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.		
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Benefits are limited as follows: 60 days per year	90% after Deductible has been met	* 70% after Deductible has been met
<b>Substance Use Disorder Services</b>		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Surgery – Outpatient</b>		
	90% after Deductible has been met	* 70% after Deductible has been met
<b>Transplantation Services</b>		
	* 90% after Deductible has been met	Non-Network Benefits are not available
	<i>For Network Benefits, services must be received at a Designated Facility.</i>	
<b>Urgent Care Center Services</b>		
	90% after Deductible has been met	70% 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.
<b>Alternative Treatments</b>
Acupuncture; aromatherapy; hypnosis; massage therapy; rolfing (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.
<b>Dental</b>
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: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. 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 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 – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.
<b>Devices, Appliances and Prosthetics</b>
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.
<b>Drugs</b>
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 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.
<b>Experimental or Investigational or Unproven Services</b>
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.
<b>Foot Care</b>
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.
<b>Medical Supplies and Equipment</b>
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"> <li>• 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.</li> <li>• Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.</li> <li>• Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.</li> </ul> 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.
<b>Mental Health / Substance Use Disorder</b>
Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental retardation as a primary diagnosis defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder 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 Unproven Services.
<b>Nutrition</b>
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 Diabetes Services in the SPD. 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.
<b>Personal Care, Comfort or Convenience</b>
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; 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.
<b>Physical Appearance</b>
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, chemosurgery 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. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

#### Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. 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. 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 disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar 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; cranosacral 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 even if 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

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. 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. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). 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). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 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. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded 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/hyperactivity disorder; TBI; or dyslexia.


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- **myuhc.com**<sup>®</sup> - 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.
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<ul style="list-style-type: none"> <li>• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.</li> </ul>		
<b>Information of Pre-service Notification</b>		
*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.		
<b>Information on Benefit Limits</b>		
<ul style="list-style-type: none"> <li>• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.</li> <li>• Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid.</li> <li>• When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.</li> </ul>		

**BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Ambulance Services – Emergency and Non-Emergency</b>		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
<b>Dental Services – Accident Only</b>		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
<b>Durable Medical Equipment (DME)</b>		
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.	90% after Deductible has been met	** 70% after Deductible has been met
<b>Emergency Health Services - Outpatient</b>		
	90% after Deductible has been met	* 90% after Network Deductible has been met

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<b>BENEFITS</b>		
Types of Coverage	Network Benefits	Non-Network Benefits
<b>Hearing Aids</b>		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	90% after Deductible has been met	70% after Deductible has been met
<b>Home Health Care</b>		
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met	* 70% after Deductible has been met
<b>Hospice Care</b>		
	90% after Deductible has been met	* 70% after Deductible has been met
<b>Hospital – Inpatient Stay</b>		
	90% after Deductible has been met	* 70% after Deductible has been met
<b>Lab, X-Ray and Diagnostics - Outpatient</b>		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90% after Deductible has been met	* 70% after Deductible has been met
<b>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>		
	90% after Deductible has been met	70% after Deductible has been met
<b>Mental Health Services</b>		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</b>		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	90% after Deductible has been met	70% after Deductible has been met
<b>Physician Fees for Surgical and Medical Services</b>		
	90% after Deductible has been met	70% after Deductible has been met
<b>Physician's Office Services – Sickness and Injury</b>		
Primary Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
<b>Pregnancy – Maternity Services</b>		
	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.	
		<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
<b>Preventive Care Services</b>		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
<b>Prosthetic Devices</b>		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	90% after Deductible has been met	** 70% after Deductible has been met
<b>Reconstructive Procedures</b>		
	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.	
		<i>Prior Authorization is required.</i>
<b>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment</b>		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of 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.	90% after Deductible has been met	* 70% after Deductible has been met
<b>Scopic Procedures – Outpatient Diagnostic and Therapeutic</b>		
Diagnostic scopic procedures include, but are not limited	90% after Deductible has been met	70% after Deductible has been met

<b>BENEFITS</b>		
Types of Coverage	Network Benefits	Non-Network Benefits
to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.		
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Benefits are limited as follows: 60 days per year	90% after Deductible has been met	* 70% after Deductible has been met
<b>Substance Use Disorder Services</b>		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Surgery – Outpatient</b>		
	90% after Deductible has been met	* 70% after Deductible has been met
<b>Transplantation Services</b>		
	* 90% after Deductible has been met	Non-Network Benefits are not available
	<i>For Network Benefits, services must be received at a Designated Facility.</i>	
<b>Urgent Care Center Services</b>		
	90% after Deductible has been met	70% after Deductible has been met

<b>MEDICAL EXCLUSIONS</b>
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.
<b>Alternative Treatments</b>
Acupuncture; aromatherapy; hypnosis; massage therapy; rolfing (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.
<b>Dental</b>
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: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. 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 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 – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.
<b>Devices, Appliances and Prosthetics</b>
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.
<b>Drugs</b>
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 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.
<b>Experimental or Investigational or Unproven Services</b>
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.
<b>Foot Care</b>
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.
<b>Medical Supplies and Equipment</b>
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"> <li>• 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.</li> <li>• Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.</li> <li>• Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.</li> </ul> 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.
<b>Mental Health / Substance Use Disorder</b>
Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental retardation as a primary diagnosis defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder 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 Unproven Services.
<b>Nutrition</b>
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 Diabetes Services in the SPD. 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.
<b>Personal Care, Comfort or Convenience</b>
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; 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.
<b>Physical Appearance</b>
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, chemosurgery 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. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

#### Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. 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. 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 disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar 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; cranosacral 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 even if 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

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. 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. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). 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). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 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. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded 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.




**Benefit Summary  
ASO Choice Plus**

Florida Municipal Insurance Trust HSA Family Medical Plan 6

United HealthCare Services, Inc. and Florida Municipal Insurance Trust 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**<sup>®</sup> - 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
<b>Annual Deductible – Combined Medical and Pharmacy</b>		
Individual Deductible	\$2,600 per year	\$5,000 per year
Family Deductible	\$5,000 per year	\$10,000 per year
<b>Out-of-Pocket Maximum – Combined Medical and Pharmacy</b>		
Individual Out-of-Pocket Maximum	\$5,000 per year	\$10,000 per year
Family Out-of-Pocket Maximum	\$10,000 per year	\$20,000 per year
<ul style="list-style-type: none"> <li>• The Out-of-Pocket Maximum includes the Annual Deductible.</li> <li>• Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.</li> <li>• Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.</li> </ul>		
<b>Benefit Plan Coinsurance – The Amount the Plan Pays</b>		
	80% after Deductible has been met	70% after Deductible has been met
<b>Prescription Drug Benefits</b>		
<ul style="list-style-type: none"> <li>• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.</li> </ul>		
<b>Information of Pre-service Notification</b>		
<i>*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)</i> <i>**Prior Authorization is required for Equipment in excess of \$1,000.</i>		
<b>Information on Benefit Limits</b>		
<ul style="list-style-type: none"> <li>• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.</li> <li>• Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid.</li> <li>• When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.</li> </ul>		

**BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Ambulance Services – Emergency and Non-Emergency</b>		
	* 80% after Deductible has been met	* 80% after Network Deductible has been met
<b>Dental Services – Accident Only</b>		
	* 80% after Deductible has been met	* 80% after Network Deductible has been met
<b>Durable Medical Equipment (DME)</b>		
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.	80% after Deductible has been met	** 70% after Deductible has been met
<b>Emergency Health Services - Outpatient</b>		
	80% after Deductible has been met	* 80% after Network Deductible has been met

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<b>BENEFITS</b>		
Types of Coverage	Network Benefits	Non-Network Benefits
<b>Hearing Aids</b>		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met	70% after Deductible has been met
<b>Home Health Care</b>		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met	* 70% after Deductible has been met
<b>Hospice Care</b>		
	80% after Deductible has been met	* 70% after Deductible has been met
<b>Hospital – Inpatient Stay</b>		
	80% after Deductible has been met	* 70% after Deductible has been met
<b>Lab, X-Ray and Diagnostics - Outpatient</b>		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	80% after Deductible has been met	* 70% after Deductible has been met
<b>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>		
	80% after Deductible has been met	70% after Deductible has been met
<b>Mental Health Services</b>		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</b>		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	80% after Deductible has been met	70% after Deductible has been met
<b>Physician Fees for Surgical and Medical Services</b>		
	80% after Deductible has been met	70% after Deductible has been met
<b>Physician's Office Services – Sickness and Injury</b>		
Primary Physician Office Visit	80% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	80% after Deductible has been met	* 70% after Deductible has been met
<b>Pregnancy – Maternity Services</b>		
	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.	<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
<b>Preventive Care Services</b>		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
<b>Prosthetic Devices</b>		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met	** 70% after Deductible has been met
<b>Reconstructive Procedures</b>		
	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.	<i>Prior Authorization is required.</i>
<b>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment</b>		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of 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.	80% after Deductible has been met	* 70% after Deductible has been met
<b>Scopic Procedures – Outpatient Diagnostic and Therapeutic</b>		
Diagnostic scopic procedures include, but are not limited	80% after Deductible has been met	70% after Deductible has been met

<b>BENEFITS</b>		
<b>Types of Coverage</b>	<b>Network Benefits</b>	<b>Non-Network Benefits</b>
to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.		
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met	* 70% after Deductible has been met
<b>Substance Use Disorder Services</b>		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Surgery – Outpatient</b>		
	80% after Deductible has been met	* 70% after Deductible has been met
<b>Transplantation Services</b>		
	* 80% after Deductible has been met	Non-Network Benefits are not available
	<i>For Network Benefits, services must be received at a Designated Facility.</i>	
<b>Urgent Care Center Services</b>		
	80% after Deductible has been met	70% after Deductible has been met

<b>MEDICAL EXCLUSIONS</b>
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.
<b>Alternative Treatments</b>
Acupuncture; aromatherapy; hypnosis; massage therapy; rolfing (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.
<b>Dental</b>
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: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. 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 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 – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.
<b>Devices, Appliances and Prosthetics</b>
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.
<b>Drugs</b>
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 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.
<b>Experimental or Investigational or Unproven Services</b>
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.
<b>Foot Care</b>
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.
<b>Medical Supplies and Equipment</b>
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"> <li>• 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.</li> <li>• Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.</li> <li>• Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.</li> </ul> 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.
<b>Mental Health / Substance Use Disorder</b>
Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental retardation as a primary diagnosis defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder 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 Unproven Services.
<b>Nutrition</b>
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 Diabetes Services in the SPD. 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.
<b>Personal Care, Comfort or Convenience</b>
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; 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.
<b>Physical Appearance</b>
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, chemosurgery 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. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

#### Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. 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. 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 disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar 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; cranosacral 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 even if 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

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. 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. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). 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). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 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. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded 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/hyperactivity disorder; TBI; or dyslexia.


**Benefit Summary  
ASO Choice Plus**

Florida Municipal Insurance Trust HSA Medical Plan 6

United HealthCare Services, Inc. and Florida Municipal Insurance Trust 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**<sup>®</sup> - 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
<b>Annual Deductible – Combined Medical and Pharmacy</b>		
Individual Deductible	\$2,500 per year	\$5,000 per year
Family Deductible	\$5,000 per year	\$10,000 per year
<b>Out-of-Pocket Maximum – Combined Medical and Pharmacy</b>		
Individual Out-of-Pocket Maximum	\$5,000 per year	\$10,000 per year
Family Out-of-Pocket Maximum	\$10,000 per year	\$20,000 per year
<ul style="list-style-type: none"> <li>• The Out-of-Pocket Maximum includes the Annual Deductible.</li> <li>• Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.</li> <li>• Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.</li> </ul>		
<b>Benefit Plan Coinsurance – The Amount the Plan Pays</b>		
	80% after Deductible has been met	70% after Deductible has been met
<b>Prescription Drug Benefits</b>		
<ul style="list-style-type: none"> <li>• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.</li> </ul>		
<b>Information of Pre-service Notification</b>		
<i>*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)</i> <i>**Prior Authorization is required for Equipment in excess of \$1,000.</i>		
<b>Information on Benefit Limits</b>		
<ul style="list-style-type: none"> <li>• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.</li> <li>• Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid.</li> <li>• When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.</li> </ul>		

**BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Ambulance Services – Emergency and Non-Emergency</b>		
	* 80% after Deductible has been met	* 80% after Network Deductible has been met
<b>Dental Services – Accident Only</b>		
	* 80% after Deductible has been met	* 80% after Network Deductible has been met
<b>Durable Medical Equipment (DME)</b>		
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.	80% after Deductible has been met	** 70% after Deductible has been met
<b>Emergency Health Services - Outpatient</b>		
	80% after Deductible has been met	* 80% after Network Deductible has been met

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<b>BENEFITS</b>		
Types of Coverage	Network Benefits	Non-Network Benefits
<b>Hearing Aids</b>		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met	70% after Deductible has been met
<b>Home Health Care</b>		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met	* 70% after Deductible has been met
<b>Hospice Care</b>		
	80% after Deductible has been met	* 70% after Deductible has been met
<b>Hospital – Inpatient Stay</b>		
	80% after Deductible has been met	* 70% after Deductible has been met
<b>Lab, X-Ray and Diagnostics - Outpatient</b>		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	80% after Deductible has been met	* 70% after Deductible has been met
<b>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>		
	80% after Deductible has been met	70% after Deductible has been met
<b>Mental Health Services</b>		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</b>		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	80% after Deductible has been met	70% after Deductible has been met
<b>Physician Fees for Surgical and Medical Services</b>		
	80% after Deductible has been met	70% after Deductible has been met
<b>Physician's Office Services – Sickness and Injury</b>		
Primary Physician Office Visit	80% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	80% after Deductible has been met	* 70% after Deductible has been met
<b>Pregnancy – Maternity Services</b>		
	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.	<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
<b>Preventive Care Services</b>		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
<b>Prosthetic Devices</b>		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met	** 70% after Deductible has been met
<b>Reconstructive Procedures</b>		
	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.	<i>Prior Authorization is required.</i>
<b>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment</b>		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of 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.	80% after Deductible has been met	* 70% after Deductible has been met
<b>Scopic Procedures – Outpatient Diagnostic and Therapeutic</b>		
Diagnostic scopic procedures include, but are not limited	80% after Deductible has been met	70% after Deductible has been met

<b>BENEFITS</b>		
<b>Types of Coverage</b>	<b>Network Benefits</b>	<b>Non-Network Benefits</b>
to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.		
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met	* 70% after Deductible has been met
<b>Substance Use Disorder Services</b>		
	Inpatient: 80% after Deductible has been met Outpatient: 80% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
<b>Surgery – Outpatient</b>		
	80% after Deductible has been met	* 70% after Deductible has been met
<b>Transplantation Services</b>		
	* 80% after Deductible has been met	Non-Network Benefits are not available
	<i>For Network Benefits, services must be received at a Designated Facility.</i>	
<b>Urgent Care Center Services</b>		
	80% after Deductible has been met	70% after Deductible has been met

<b>MEDICAL EXCLUSIONS</b>
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.
<b>Alternative Treatments</b>
Acupuncture; aromatherapy; hypnosis; massage therapy; rolfing (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.
<b>Dental</b>
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: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. 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 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 – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.
<b>Devices, Appliances and Prosthetics</b>
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.
<b>Drugs</b>
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 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.
<b>Experimental or Investigational or Unproven Services</b>
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.
<b>Foot Care</b>
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.
<b>Medical Supplies and Equipment</b>
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"> <li>• 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.</li> <li>• Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.</li> <li>• Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.</li> </ul> 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.
<b>Mental Health / Substance Use Disorder</b>
Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental retardation as a primary diagnosis defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder 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 Unproven Services.
<b>Nutrition</b>
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 Diabetes Services in the SPD. 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.
<b>Personal Care, Comfort or Convenience</b>
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; 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.
<b>Physical Appearance</b>
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, chemosurgery 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. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

#### Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. 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. 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 disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar 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; cranosacral 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 even if 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

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. 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. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). 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). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 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. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded 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/hyperactivity disorder; TBI; or dyslexia.





 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-518-8079 or visit [welcometouhc.com](http://welcometouhc.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><u>Network</u>: <b>\$1,300</b> Individual / <b>\$2,600</b> Family  <u>Non-Network</u>: <b>\$2,500</b> Individual / <b>\$5,000</b> Family                      Per calendar year.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><u>Network</u>: <b>\$3,750</b> Individual / <b>\$7,500</b> Family  <u>Non-Network</u>: <b>\$7,500</b> Individual / <b>\$15,000</b> Family                      Per calendar year.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://myuhc.com">myuhc.com</a> or call <b>1-844-518-8079</b> for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Virtual visits (Telehealth) - 10% <a href="#">coinsurance</a> by a Designated Virtual <a href="#">Network Provider</a> .
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/</a> Immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. No coverage non- <a href="#">network</a>
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required non- <a href="#">network</a> for certain services or benefit reduces to 50% of <a href="#">allowed amount</a> .
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">welcometouhc.com</a>	Tier 1 – Your Lowest Cost Option	Retail: \$10 <a href="#">copay</a> Mail-Order: \$25 <a href="#">copay</a>	Retail: \$10 <a href="#">copay</a>	<a href="#">Provider</a> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <a href="#">specialty drugs</a> , from a pharmacy designated by us. Certain drugs may have a <a href="#">preauthorization</a> requirement or may result in a higher cost. If you use a non- <a href="#">network</a> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <a href="#">allowed amount</a> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <a href="#">plan</a> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <a href="#">copay</a> and/or <a href="#">coinsurance</a> may be applied. Prescription drug costs are subject to the annual <a href="#">deductible</a> . <a href="#">Network deductible</a> will be applied to the non- <a href="#">network provider</a> and applies to the <a href="#">Network out-of-pocket limit</a>
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 <a href="#">copay</a> Mail-Order: \$87.50 <a href="#">copay</a>	Retail: \$35 <a href="#">copay</a>	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$60 <a href="#">copay</a> Mail-Order: \$150 <a href="#">copay</a>	Retail: \$60 <a href="#">copay</a>	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required non- <a href="#">network</a> for certain services or benefit reduces to 50% of <a href="#">allowed amount</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <u>coinsurance</u>	*10% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>	*10% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<a href="#">Urgent care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 10% <u>coinsurance</u> <u>Preauthorization</u> is required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
If you are pregnant	Office visits	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>preauthorization</u> applies non- <u>network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Rehabilitation services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Habilitative services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required non- <u>network</u> for DME over \$1,000 or no coverage.
	<a href="#">Hospice services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .
<b>If your child needs dental or eye care</b>	Children's eye exam	10% <u>coinsurance</u>	30% <u>coinsurance</u>	One routine vision exam, including refraction, to detect vision impairment. Routine eye exam is limited to 1 every other year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Children's glasses</li> <li>Cosmetic surgery</li> <li>Dental care</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when travelling outside - the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private duty nursing</li> <li>Routine foot care – Except as covered for Diabetes</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic (Manipulative care) – 20 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids - \$2,500 per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (adult) - 1 exam per 2 years</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](http://welcometouhc.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-518-8079.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-518-8079.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-518-8079.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-518-8079.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,300
■ <a href="#">Specialist</a> coinsurance <a href="#">copay</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,390</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,300
■ <a href="#">Specialist</a> coinsurance <a href="#">copay</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$60
What isn't covered	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$2,290</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,300
■ <a href="#">Specialist</a> coinsurance <a href="#">copay</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$60
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,360</b>

We do 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 number listed within this Summary of Benefits and Coverage (SBC) , 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 number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意：**如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

**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 ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص المزاي والتغطية هنا. (Summary of Benefits and Coverage, SBC)

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 nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。



توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage- SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल 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 dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.


ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániliti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shòqdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' 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 bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-518-8079 or visit [welcometouhc.com](http://welcometouhc.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><u>Network</u>: <b>\$2,600</b> Individual / <b>\$2,600</b> Family  <u>Non-Network</u>: <b>\$2,500</b> Individual / <b>\$5,000</b> Family                      Per calendar year.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><u>Network</u>: <b>\$3,750</b> Individual / <b>\$7,500</b> Family  <u>Non-Network</u>: <b>\$7,500</b> Individual / <b>\$15,000</b> Family                      Per calendar year.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://myuhc.com">myuhc.com</a> or call <b>1-844-518-8079</b> for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Virtual visits (Telehealth) - 10% <a href="#">coinsurance</a> by a Designated Virtual <a href="#">Network Provider</a> .
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/Immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. No coverage non- <a href="#">network</a>
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required non- <a href="#">network</a> for certain services or benefit reduces to 50% of <a href="#">allowed amount</a> .
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">welcometouhc.com</a>	Tier 1 – Your Lowest Cost Option	Retail: \$10 <a href="#">copay</a> Mail-Order: \$25 <a href="#">copay</a>	Retail: \$10 <a href="#">copay</a>	<a href="#">Provider</a> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <a href="#">specialty drugs</a> , from a pharmacy designated by us. Certain drugs may have a <a href="#">preauthorization</a> requirement or may result in a higher cost. If you use a non- <a href="#">network</a> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <a href="#">allowed amount</a> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <a href="#">plan</a> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <a href="#">copay</a> and/or <a href="#">coinsurance</a> may be applied. Prescription drug costs are subject to the annual <a href="#">deductible</a> . <a href="#">Network deductible</a> will be applied to the non- <a href="#">network provider</a> and applies to the <a href="#">Network out-of-pocket limit</a>
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 <a href="#">copay</a> Mail-Order: \$87.50 <a href="#">copay</a>	Retail: \$35 <a href="#">copay</a>	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$60 <a href="#">copay</a> Mail-Order: \$150 <a href="#">copay</a>	Retail: \$60 <a href="#">copay</a>	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required non- <a href="#">network</a> for certain services or benefit reduces to 50% of <a href="#">allowed amount</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <u>coinsurance</u>	*10% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>	*10% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<a href="#">Urgent care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 10% <u>coinsurance</u> <u>Preauthorization</u> is required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
If you are pregnant	Office visits	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>preauthorization</u> applies non- <u>network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Rehabilitation services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Habilitative services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required non- <u>network</u> for DME over \$1,000 or no coverage.
	<a href="#">Hospice services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .
<b>If your child needs dental or eye care</b>	Children's eye exam	10% <u>coinsurance</u>	30% <u>coinsurance</u>	One routine vision exam, including refraction, to detect vision impairment. Routine eye exam is limited to 1 every other year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Children's glasses</li> <li>Cosmetic surgery</li> <li>Dental care</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when travelling outside - the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private duty nursing</li> <li>Routine foot care – Except as covered for Diabetes</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic (Manipulative care) – 20 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids - \$2,500 per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (adult) - 1 exam per 2 years</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](http://welcometouhc.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-518-8079.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-518-8079.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-518-8079.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-518-8079.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)		<b>Managing Joe's type 2 Diabetes</b> (a year of routine in-network care of a well-controlled condition)		<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)																																											
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,600	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,600	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,600																																										
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<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )																																											
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>																																										
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

We do 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 number listed within this Summary of Benefits and Coverage (SBC) , 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 number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意：**如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

**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 ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.



알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص المزاي والتغطية هنا. (Summary of Benefits and Coverage, SBC)

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 nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage- SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल 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 dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániliti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shòqdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' 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 bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-518-8079, or visit [welcometouhc.com](http://welcometouhc.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><u>Network</u>: <b>\$2,500</b> Individual / <b>\$5,000</b> Family  <u>Non-Network</u>: <b>\$5,000</b> Individual / <b>\$10,000</b> Family                      Per calendar year.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><u>Network</u>: <b>\$5,000</b> Individual / <b>\$10,000</b> Family  <u>Non-Network</u>: <b>\$10,000</b> Individual / <b>\$20,000</b> Family                      Per calendar year.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://myuhc.com">myuhc.com</a> or call <b>1-844-518-8079</b> for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Virtual visits (Telehealth) - 20% <a href="#">coinsurance</a> by a Designated Virtual <a href="#">Network Provider</a> .
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/Immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. No coverage non- <a href="#">network</a>
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required non- <a href="#">network</a> for certain services or benefit reduces to 50% of <a href="#">allowed amount</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">welcometouhc.com</a>	Tier 1 – Your Lowest Cost Option	Retail: \$10 <a href="#">copay</a> Mail-Order: \$25 <a href="#">copay</a>	Retail: \$10 <a href="#">copay</a>	<a href="#">Provider</a> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <a href="#">specialty drugs</a> , from a pharmacy designated by us. Certain drugs may have a <a href="#">preauthorization</a> requirement or may result in a higher cost. If you use a non- <a href="#">network</a> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <a href="#">allowed amount</a> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <a href="#">plan</a> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <a href="#">copay</a> and/or <a href="#">coinsurance</a> may be applied. Prescription drug costs are subject to the annual <a href="#">deductible</a> . <a href="#">Network deductible</a> will be applied to the non- <a href="#">network provider</a> and applies to the <a href="#">Network out-of-pocket limit</a>
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 <a href="#">copay</a> Mail-Order: \$87.50 <a href="#">copay</a>	Retail: \$35 <a href="#">copay</a>	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$60 <a href="#">copay</a> Mail-Order: \$150 <a href="#">copay</a>	Retail: \$60 <a href="#">copay</a>	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required non- <a href="#">network</a> for certain services or benefit reduces to 50% of <a href="#">allowed amount</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> <u>Preauthorization</u> is required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
If you are pregnant	Office visits	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>preauthorization</u> applies non- <u>network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Habilitative services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required non- <u>network</u> for DME over \$1,000 or no coverage.
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .
<b>If your child needs dental or eye care</b>	Children's eye exam	20% <u>coinsurance</u>	30% <u>coinsurance</u>	One routine vision exam, including refraction, to detect vision impairment. Routine eye exam is limited to 1 every other year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Children's glasses</li> <li>• Cosmetic surgery</li> <li>• Dental care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when travelling outside - the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care – Except as covered for Diabetes</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Chiropractic (Manipulative care) – 20 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids - \$2,500 per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult) - 1 exam per 2 years</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](http://welcometouhc.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-518-8079.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-518-8079.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-518-8079.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-518-8079.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist</a> coinsurance copay	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,390</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist</a> coinsurance copay	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$3,320</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist</a> coinsurance copay	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>



We do 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 number listed within this Summary of Benefits and Coverage (SBC) , 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 number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意：**如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

**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 ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص المزاي والتغطية هنا. (Summary of Benefits and Coverage, SBC)

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 nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage- SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल 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 dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.


ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániliti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shòqdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' 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 bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-518-8079, or visit [welcometouhc.com](http://welcometouhc.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><u>Network</u>: <b>\$2,600</b> Individual / <b>\$5,000</b> Family  <u>Non-Network</u>: <b>\$5,000</b> Individual / <b>\$10,000</b> Family                      Per calendar year.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><u>Network</u>: <b>\$5,000</b> Individual / <b>\$10,000</b> Family  <u>Non-Network</u>: <b>\$10,000</b> Individual / <b>\$20,000</b> Family                      Per calendar year.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://myuhc.com">myuhc.com</a> or call <b>1-844-518-8079</b> for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Virtual visits (Telehealth) - 20% <a href="#">coinsurance</a> by a Designated Virtual <a href="#">Network Provider</a> .
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/</a> Immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. No coverage non- <a href="#">network</a>
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required non- <a href="#">network</a> for certain services or benefit reduces to 50% of <a href="#">allowed amount</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">welcometouhc.com</a>	Tier 1 – Your Lowest Cost Option	Retail: \$10 <a href="#">copay</a> Mail-Order: \$25 <a href="#">copay</a>	Retail: \$10 <a href="#">copay</a>	<a href="#">Provider</a> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <a href="#">specialty drugs</a> , from a pharmacy designated by us. Certain drugs may have a <a href="#">preauthorization</a> requirement or may result in a higher cost. If you use a non- <a href="#">network</a> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <a href="#">allowed amount</a> . Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <a href="#">plan</a> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <a href="#">copay</a> and/or <a href="#">coinsurance</a> may be applied. Prescription drug costs are subject to the annual <a href="#">deductible</a> . <a href="#">Network deductible</a> will be applied to the non- <a href="#">network provider</a> and applies to the <a href="#">Network out-of-pocket limit</a>
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 <a href="#">copay</a> Mail-Order: \$87.50 <a href="#">copay</a>	Retail: \$35 <a href="#">copay</a>	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$60 <a href="#">copay</a> Mail-Order: \$150 <a href="#">copay</a>	Retail: \$60 <a href="#">copay</a>	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required non- <a href="#">network</a> for certain services or benefit reduces to 50% of <a href="#">allowed amount</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Network</u> Partial hospitalization/intensive outpatient treatment: 20% <u>coinsurance</u> <u>Preauthorization</u> is required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
If you are pregnant	Office visits	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>preauthorization</u> applies non- <u>network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> .
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Habilitative services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above. <u>Preauthorization</u> required non- <u>network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per calendar year (combined with inpatient rehabilitation). <u>Preauthorization</u> is required non- <u>network</u> or benefit reduces to 50% of <u>allowed amount</u> .
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Preauthorization</u> is required non- <u>network</u> for DME over \$1,000 or no coverage.
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required non- <u>network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> .
<b>If your child needs dental or eye care</b>	Children's eye exam	20% <u>coinsurance</u>	30% <u>coinsurance</u>	One routine vision exam, including refraction, to detect vision impairment. Routine eye exam is limited to 1 every other year.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Children's glasses</li> <li>• Cosmetic surgery</li> <li>• Dental care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when travelling outside - the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care – Except as covered for Diabetes</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Chiropractic (Manipulative care) – 20 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids - \$2,500 per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult) - 1 exam per 2 years</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [welcometouhc.com](http://welcometouhc.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-518-8079.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-518-8079.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-518-8079.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-518-8079.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,600
■ <a href="#">Specialist</a> coinsurance copay	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,600
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$1,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,490</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,600
■ <a href="#">Specialist</a> coinsurance copay	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,600
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$70
What isn't covered	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$3,400</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,600
■ <a href="#">Specialist</a> coinsurance copay	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

We do 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 number listed within this Summary of Benefits and Coverage (SBC) , 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 number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意：**如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

**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 ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص المزايا والتغطية هنا. (Summary of Benefits and Coverage, SBC)

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 nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage- SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल 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 dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániliti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shòqdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' 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 bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).