ADDENDUM NO. 1

AUGUST 12, 2019

Solicitation Title: **Agent of Record for Employee Benefit Programs**

Solicitation No.: **RFP 71-18-19**

Due Date: **Thursday, August 22, 2019 By 3:30 PM**

Attention all potential bidders:

☒ **MUST Addendum**: Read carefully and follow all instructions. Information included in this Addendum will have a material impact on the submittal for this solicitation. All "MUST" addenda are considered a matter of responsiveness. "MUST" addenda must be acknowledged on Form "A-5". Failure of a Submitter to acknowledge the addenda shall be cause for rejection of the bid.

Note: Please be advised that the opportunity to submit questions and/or requests for clarifications regarding this Solicitation is solely for the purpose of clarifying the scope of services, eligibility criteria, performance requirements and procedural matters related to the selection, award and expectations of the City for this contract.

To all prospective bidders, please note the following questions and/or requests for clarifications:

Q.1 To receive credit for local vendor preference is the following needed for compliance of Section 7-151 in the City Code:

Q.1A Do the office hours need to be posted and an employee required to be there each business day?

A.1A Section 7-151 does not establish requisite office hours or required number of employees to be present at the business location.

Q.1B Are there minimum requirements for office hours (CNM employees can come in to discuss issues, questions, claims, etc.)?

A.1B Section 7-151 does not set forth requisite office hours for purposes of establishing local business preference.

Q.1C Does a licensed HIPAA certified agent need to be available at the location to answer questions?

A.1C Section 7-151 does not set forth any requirements for HIPAA certified agents.

Q.1D Does the office need to have identifiable signage indicating the presence of said company?

A.1D Section 7-151 does not set forth any requirements for signage.

Q.1E Does the office need to be established prior to the first RFP that was issued on May 28th, 2018 based on the fact that the subsequent RFPs are a continuation of the process?

A.1E Local Business must have been established prior to the issuance of this Solicitation on July 22, 2019.

Q.2 Under what circumstance would a change to the RFP requirements happen and who has the authority to make those changes? Is that request required to be written and part of public records? For example, in RFP #35-18-19, there were two addendums with major changes:

A. Addendum 2 issued on 5/16/19: change to qualifications and change to the RFP deadline date

1. Who requested those changes – the City, a company participating in the RFP process and/or an interested party?

B. Addendum 3 issued on 5/24/19 at 4:54 pm: change made to RFP deadline after the deadline had passed (3:30 pm on 5/24/19)

1. Who requested those changes – the City, a company participating in the RFP process and/or an interested party?

A.2 This Solicitation provided an opportunity for interested parties to submit questions and/or requests for clarification related to the subject matter of the Solicitation and/or procedural aspects of the Solicitation itself. However, most of the questions included above or either hypothetical in nature or not germane to this Solicitation at all, but rather to a previous RFP.

As a matter of clarification, there are any number off reasons for changes to be made to this or any other solicitation. The Purchasing Department is responsible for the issuance of any such changes, in consultation with the appropriate City staff, if necessary. Such discussions regarding potential changes can be either verbal and/or in writing.

Q.3 What are the expectations/services that will be required throughout the year for on-site: annual open enrollment, monthly open enrollments, wellness activities, and claims advocacy, if the agency selected is outside of the local area (e.g. a company that is located 200+ miles away)??

A.3 It is required that the selected vendor provide face to face meetings for all activities listed above and additional face to face interaction on an as-needed basis.

Q.4 Are phone calls made to commission members and the mayor prior to the final commission vote a violation of the cone of silence?

A.4 Any phone calls made to commission members and the mayor **after** the City Manager's written recommendation of award is **not** in violation of the cone of silence.

Q.5 When does the cone of silence end?

A.5 The cone of silence is lifted at the time the City Manager provides a written recommendation of award.

Q.6 Does the City require that the following services be included as part of the Schedule of Fees in the RFP? Hours are approximated and based on a one year period of time:

Q.6A Monthly on-site new hire and enrollment meetings (24 – 48 hours).
A.6A Yes. On an as-needed basis.

Q.6B Resolution of online technical issues with employees (36 hours)
A.6B Yes. On an as-needed basis.

Q.6C Management and audit of weekly carrier error reports (104 hours)
A.6C Yes. On an as-needed basis.

Q.6D During the annual open enrollment period:
Q.6D1 On-site open enrollment meetings/enrollment process (16 hours)
A.6D1 Yes. On an as-needed basis.

Q.6D2 Consultations for updating and maintenance of Plan Source (40-60 hours)
A.6D2 Yes. On an as-needed basis.

Q.6D3 Consultations required to create connection between carriers and Plan Source (80 hours during)
A.6D3 Yes. On an as-needed basis.

Q.6D4 Audit of open enrollment files to check on incomplete enrollments (24-36 hours during)
A.6D4 Yes. On an as-needed basis.

Q.6D5 Audit of final carrier feed file submission (16-24 hours)
A.6D5 Yes. On an as-needed basis.

Q.6E On-going audits of carrier discrepancy reports (26 hours)
A.6E Yes. On an as-needed basis.

Q.6F Creation of benefit books, contribution spreadsheets, enrollment flyers, wellness flyers and any other marketing needs.
A.6F Yes.

Q.6G Claims
Q.6G1 On-site claims advocates (900 – 1,000 hours)
A.6G1 Yes. On an as-needed basis.

Q.6G2 Resolution of claims and eligibility issues for retirees (50 – 100 hours)
A.6G2 Yes. On an as-needed basis.

Q.6H Wellness (100 hours)
1. Quarterly meetings with in-house wellness team to evaluate and decide on future events.
2. Meeting with carrier to review and capitalize on all carrier resources.
3. Update activity/events calendar.
4. Submit applications on behalf of the City for awards (e.g. Healthiest Employer, Florida Worksite Wellness, etc.).

5. Vet all vendor for City Wellness Coordinator and serve as point of contact for events.
6. Collect data and provide reporting.
7. Monthly events coordination.
8. Two wellness days – coordination and in-house staff participation.

A.6H Yes. On an as-needed basis.

Q.7 Pages 14 and 15 Section 2.7 INSURANCE – Please confirm if the City is willing to accept the Auto Liability based on Auto limits on any one accident or loss?

A.7 Yes.

Q.8 Pages 14 and 15 Section 2.7 INSURANCE – Please confirm if the City is willing to accept that our professional liability limits are each wrongful act/annual aggregate and our policy has a $5 million retention. Our annual report is available online for the City to review.

A.8 The $5 million retention is too high. Although the requirements call for $25K retention, the City may consider acceptance of a higher retention such as $100,000 if an award is made (after a favorable review of financials).

Q.9 Pages 14 and 15 Section 2.7 INSURANCE – With regards to WOS we would request that the waiver of the insurer's subrogation rights with WC, EL, GL and Al be removed or if not, will the City allow mutual waivers under the other party's policies?

A.9 The Waiver of Subrogation in favor of the City of North Miami shall remain. City is amenable to discuss mutual waivers if an award is made.

Q.10 Pages 14 and 15 Section 2.7 INSURANCE – Please confirm if the City would allow the Awardee to advise that a canceled, or non-renewed policy would be replaced with no coverage gap and a current COI would be provided and not provide a cancellation notice, since coverage will be replaced with no gap?

A.10 The City must be notified in writing either by the awardee or carrier of any actual policy changes (such as a change in the carrier or impending cancellation or non-renewal), albeit we will accept a COI with replacement coverage showing no gap in coverage.

Q.11 Section 2.7.5 - Our primary policy limits are sufficient to meet the limits requirements in the agreement. We do not track claims that erode policy limits, if necessary we have Umbrella or Excess policy limits if primary limits are exhausted. Is this acceptable to the City?

A.11 Umbrella policy is acceptable with a "Broad as Primary Endorsement".

Q.12 Pages 14 and 15 – Indemnification: Please confirm if the City is willing to accept the indemnification be limited to losses and damages as a result of our negligence and covered under the terms of our general liability policy; any wrongful acts solely in rendering or failing to render professional services and covered under our professional liability policy; or, any claim alleging a security failure, privacy event or wrongful act and covered under our cyber liability policy (misappropriation of trade secret or, infringement of patent are exclusions in our cyber policy).

A.12 Will accept indemnification for loss/damage due to your negligence in the G/L policy; the Professional Liability policy will be required to provide coverage for errors and omissions occurring while rendering professional services, separate from that provided under the cyber liability policy (for copyright, trademark, infringement, etc).

Q.13 Scope of Services – Item 5 – Are you requesting the Broker/Consultant pay for these services or just assist in review of the process and current vendor?

A.13 The City is requesting the Broker/Consultant to pay for the platform and maintenance.

Q.14 Scope of Services – Item 6 and 8 – Are you requesting the Broker/Consultant pay for an online enrollment system? If so, what system is the City using today? What is the cost of the system? Does the City want to change systems?

A.14 The City is requesting the vendor pay for the platform and maintenance. Currently, the City uses PlanSource. The cost of the system is unknown to the City. The City is open to changing systems after year one of the contract.

Q.15 Scope of Services – Item 10 – How is the call center handled today, are these services outsourced or handled internally by the current consultant? What has been the utilization of these services (i.e. how many calls per month for the past 12 months)?

A. 15 The call center is handled internally by the current consultant.

Q.16 Scope of Services – Item 12 – What technology platform is currently in place? Is the City looking to make changes, if so why? What is the current cost of the technology platform? If a change is made are you able to extrapolate the data to be implanted in the new system?

A.16 Currently, the City uses PlanSource. The cost of the system is unknown to the City. The current broker pays for it. The City is open to changing systems after year one of the contract. The City is able to export the data from Plansource to import into a new system if the decision is made by the city to change platforms.

Q.17 Scope of Services – Item 16 – How are these questions currently being addressed? On average, how many questions are asked per month? What types of questions are currently being asked?

A.17 The current vendor has claim agents available to answer questions or assist with claim issues by either phone or email. The turnaround time varies but normally within 48 hours. We do not track how many questions are asked per month.

Q.18 Scope of Services – Item 17 - Clarify is “dedicated” agent can work on other clients or just the City? How often has the City used these agents in the past 12 months?

A.18 They can work with other clients; however, the City does need an assigned agent. The City uses the agent frequently.

Q.19 Scope of Services – Item 18 - Does the City currently have a wellness program in place? If so, what programs/services are being offered through the wellness program. Does the City have an established Wellness Committee?

A.19 Yes, the City has a Wellness Program and Wellness Committee. The City currently, has fitness programs multiple times a week and very quarterly.

Q.20 Scope of Services – Item 21 - Is the request for the broker/consultant to find a provider for these services or pay for these services? What/Who is currently being used? What is the cost of the current program?

A.20 Yes, requesting the broker/consultant to find a provider and pay for the services. Currently, the City uses PlanSource. The cost of the system is unknown to the City since the current broker pays for it.

Q.21 Scope of Services – Item 30 – Is this currently performed under the current agreement? Please provide a current example.

A.21 Yes. Please see “Attachment A” for current example.

Q.22 Can you provide the current agreement and annual compensation of the incumbent insurance broker?

A.22 Please see “Attachment B” for current agreement. The annual compensation rate of commission is 3.5% paid by the vendor.

Q.23 This RFP was out the middle of 2018 & again in 2019, what is causing the RFP to be rejected and why is the RFP out again so soon?

A.23 The City reserves the right to cancel and/or re-advertise and re-solicit Solicitations at any time when determined to be in the best interest of the City.

Q.24 RFP Due Date: Would the City consider extending the closing date?

A.24 No.

Q.25 Please provide us the premium vs. claims report for the 2017 and 2018 plan year. These reports should come from the insurance carrier in either PDF or Excel format.

A.25 Please see “Attachment C” for claims report.

Q.26 Please provide a de-identified large claim report for the 2017 and 2018 plan year.

A.26 Please see “Attachment D” for large claims report.

Q.27 Please include utilization reports from the carrier from the 2017 and 2018 plan year.

A.27 Please see “Attachment C” for claims report.

Q.28 Please provide the plan designs offered to employees during the 2017, 2018, and 2019 plan year.

A.28 Please see “Attachment E, F, G” for Plan Design Medical

Q.29 Please describe the current wellness program.

A.29 The voluntary Wellness Program encourages employees to make behavioral changes to help prevent and/or reverse the onset of chronic diseases. The resources include training and education, physical activities, lunch and learn programs, and online information that promotes employee overall well-being. We are constantly searching for ways to keep healthcare costs under control and ultimately reduce them as much as possible

Q.30 Please provide the wellness program details from the prior carrier. (UHC and Rally Health).

A.30 The program is similar to the current wellness program.

All other terms, conditions, and specifications remain unchanged for this Solicitation.

End of Addendum.

Attachment A

City of North Miami | 776 NE 125 Street 1st Floor | North Miami, FL 33161

Generated: August 07, 2019

Benefits Confirmation Statement

Each benefit election you have made is listed below.

Your enrollment will be complete when you **click Confirm** at the bottom of the page.

To make adjustment to your elections, click on the Enroll in Benefits link to the left.

Your Information

Name:		Email:	Class:
Address:		Employee Number:	Retiree Medical Premium Tier:
		Employment Level:	Department:
Phone:	Home:	Hire Date:	Union:
Gender:	F		
Status:	**Employee - Active**		

01/01/2019 to 12/31/2019 Elections

	Coverage	Your Cost	Employer Cost
Medical			
HNOnly OA $250 Plan	***Employee Only***	***$0.00***	***$125.63***
Start Date	01/01/2019		
Dental			
DHMO Plan	***Employee Only***	***$0.00***	***$3.12***
Start Date	01/01/2019		
Vision			
Decline	***Other***		
Original Effective Date	01/01/2019		
Basic Employee Life			
Basic Life & AD&D - Class 3	***Enrolled***	***$0.00***	***$5.96***
Start Date	01/01/2019		
Volume	$68,000.00		
Voluntary Short Term Disability			
Decline	***Decline***		
Original Effective Date	01/01/2019		
Voluntary Long Term Disability			
Decline	***Decline***		

Original Effective Date	01/01/2019

Voluntary Employee Life

Decline	***Decline***
Original Effective Date	01/01/2019

Salary Reduction Authorization

YES	***I Agree***
Start Date	01/01/2019

Per Pay Period Cost	$0.00	$134.71

Attachment B

CITY OF NORTH MIAMI
FIFTH OPTION TO RENEW
PROFESSIONAL SERVICES AGREEMENT EXTENSION
(RFQ18-07-08 AGENT OF RECORD)

THIS FIFTH OPTION TO RENEW PROFESSIONAL SERVICES AGREEMENT ("Fifth Option Agreement") is made and entered into this 19th day of September, 2018, by and between the **City of North Miami**, a Florida municipal corporation, located at 776 NE 125th Street, North Miami, FL ("City") and **Sapoznik Insurance & Associates, LLC**, a limited liability company organized and existing under the laws of the State of Florida, having its principal office at 1100 NE 163rd Street, 2nd Floor, North Miami Beach, FL 33162 ("Contractor"). The City and Contractor shall collectively be referred to as the "Parties".

RECITALS

WHEREAS, on January 13, 2009, the City entered into an agreement with Contractor ("Agreement") for the provision of Agent of Record Insurance Services for City employee's benefits plan ("Services"), in accordance with the terms, conditions and specifications contained in the City's ***Request for Qualifications # 18-07-08, Agent of Record Services for City's Employee Benefits Plans*** ("RFQ"); and

WHEREAS, the initial term of the Agreement was five (5) years from the date specified in the City's Notice to Proceed; and

WHEREAS, upon completion of the initial term, the City had the option to renew the Agreement for five (5) additional one-year terms, with the written consent of the Parties.

WHEREAS, the fourth one (1) year renewal term expires on December 31, 2018; and

WHEREAS, the City did not exercise the fifth and final option to renew the Agreement for one (1) year, opting to issue a solicitation for the agent of record services; and

WHEREAS, on May 25, 2018,the City issued **"RFP No. 54-17-18 Agent of Record for Employee Benefits Program"** seeking proposals from experienced and qualified firms.

WHEREAS, at the August 28, 2018 City Council Meeting, the Mayor and Council voted 5-0 to reject staff's recommendation presented for **RFP No 54-17-18** ,issue a new solicitation and extend the existing contract with Sapoznik for an additional one (1) year term, commencing on January 1, 2019 and concluding on December 31, 2019; and

WHEREAS, the Mayor and City Council determined that it was in the best interest of the City of North Miami for staff to proceed with a new RFP for the January 1, 2020 to December 31, 2020 term;

NOW THEREFORE, in consideration of the mutual promises and covenants set forth herein and other good and valuable consideration, the Parties hereto agree as follows:

1. The City hereby extends the Agreement for Agent of Record Services for the Employee Benefits Plans for the one (1) year term commencing January 1, 2019, through December 31, 2019.

2. The Contractor hereby accepts the City's option to extend this Agreement for the provision of Services, for the one (1) year term commencing January 1, 2019, through December 31, 2019.

3. The City shall have no options to renew the Agreement remaining.

4. The Contractor agrees to provide Services in accordance with the terms, conditions and specifications contained in the Contract Documents at the reduced commission rate of 3.5%. Additionally, both parties mutually agree that the City shall have the option to administer and exercise full control of all wellness dollars appropriated by the City's insurance provider, if it so chooses at a later date.

5. The Parties agree that this Fifth one (1) year Option Agreement shall be made part of the Agreement previously executed by the Parties, attached hereto as Exhibit "A".

6. No modification or amendment hereto shall be valid unless in writing and executed by properly authorized representatives of the Parties.

7. This Fifth one (1) year Option Agreement shall be binding upon the Parties hereto, their successors in interest, heirs, executors, assigns and personal representatives.

8. All other terms of the Agreement, which have not been modified by this Fifth one (1) year Option Agreement, shall remain in full force and effect.

[*The remainder of this page is intentionally left blank.*]

IN WITNESS WHEREOF, the Parties have executed this Agreement by their respective proper officers duly authorized the day and year first written above.

ATTEST:

Corporate Secretary or Witness:

By: Kenneth Nahman

Print Name: KENNETH NAHMAN

Title: CFO

Date: 9/17/18

Sapoznik Insurance & Associates, LLC, a Florida limited liability company:

"**Contractor**"

By: Andrew Goodman

Print Name: Andrew Goodman

Title: V.P.

Date: 9/17/18

ATTEST:

By: _____
Michael A. Etienne, Esq.
City Clerk

City of North Miami, a Florida municipal Corporation: "**City**"

By: _____
Larry M. Spring, Jr.
City Manager

APPROVED AS TO FORM AND LEGAL SUFFICIENCY:

By: _____
Jeff P.H. Cazeau, Esq.
City Attorney

Attachment C

Premium vs Claims Incurred Including IBNR - Underwriting - Non-Standard

Report Filter:

({-Policy Number} = 000706725) And ({Book Year/Month} = 2019-03, 2019-02, 2019-01, 2018-12, 2018-11, 2018-10, 2018-09, 2018-08, 2018-07, 2018-06, 2018-05, 2018-04, 2018-03, 2018-02, 2018-01, 2017-12, 2017-11, 2017-10, 2017-09, 2017-08, 2017-07, 2017-06, 2017-05, 2017-04, 2017-03, 2017-02, 2017-01, 2016-12, 2016-11, 2016-10, 2016-09, 2016-08, 2016-07, 2016-06, 2016-05, 2016-04) And ({Bill/Service Year/Month} = 2018-12, 2018-11, 2018-10, 2018-09, 2018-08, 2018-07, 2018-06, 2018-05, 2018-04, 2018-03, 2018-02, 2018-01, 2017-12, 2017-11, 2017-10, 2017-09, 2017-08, 2017-07, 2017-06, 2017-05, 2017-04, 2017-03, 2017-02, 2017-01, 2016-12, 2016-11, 2016-10, 2016-09, 2016-08, 2016-07, 2016-06, 2016-05, 2016-04) And ({Benefit Type Category} ({ID Field}) = 9 or 10) And ({Funding Arrangement Category} <> Administrative Services Only)

Premium vs Claims Incurred Including IBNR - Underwriting - Non-Standard

Please Note:

For markets moving to service fees, premiums are shown with service fees included. For markets continuing to pay commissions, premium still includes commissions.

Year/Month	Members	Subscribers	Premium	Premium PMPM	Medical Payments	Capitation Payments	Managed Pharmacy Payments	Total Payments	Claims to Premium Ratio	Total Payments PMPM	12 Month Rolling Average PMPM
2016-04	47	30	$32,083	$682.63	$9,664	$1,203	$12,716	$23,583	73.5%	$501.78	
2016-05	47	30	$32,083	$682.63	$6,586	$1,203	$13,214	$21,002	65.5%	$446.86	
2016-06	47	30	$32,083	$682.63	$3,297	$1,203	$13,237	$17,737	55.3%	$377.39	
2016-07	46	30	$31,135	$676.86	$1,186	$1,177	$9,260	$11,623	37.3%	$252.68	
2016-08	46	30	$31,135	$676.86	$17,139	$1,177	$16,382	$34,698	111.4%	$754.31	
2016-09	46	30	$31,135	$676.86	$19,560	$1,177	$13,704	$34,442	110.6%	$748.73	
2016-10	46	30	$31,135	$676.86	$2,834	$1,177	$13,383	$17,394	55.9%	$378.14	
2016-11	46	30	$31,135	$676.86	$3,210	$1,177	$13,279	$17,667	56.7%	$384.06	
2016-12	46	30	$31,135	$676.86	$1,420	$1,177	$16,097	$18,694	60.0%	$406.40	
2017-01	680	458	$292,526	$430.18	$95,485	$7,050	$37,836	$140,370	48.0%	$206.43	
2017-02	673	458	$388,887	$577.84	$364,384	$6,974	$44,481	$415,839	106.9%	$617.89	
2017-03	673	457	$388,158	$576.76	$122,290	$7,003	$69,648	$198,941	51.3%	$295.60	$389.68
2017-04	676	457	$386,443	$571.66	$82,219	$6,966	$68,647	$157,833	40.8%	$233.48	$353.59
2017-05	680	462	$389,474	$572.76	$120,523	$7,013	$94,549	$222,085	57.0%	$326.60	$347.46
2017-06	676	464	$388,795	$575.14	$140,677	$6,994	$75,382	$223,053	57.4%	$329.96	$344.40
2017-07	667	459	$384,870	$577.02	$141,909	$6,918	$35,928	$184,756	48.0%	$277.00	$336.18
2017-08	668	460	$385,510	$577.11	$175,669	$6,890	$40,943	$223,501	58.0%	$334.58	$332.54
2017-09	669	461	$385,879	$576.80	$174,594	$6,871	$55,074	$236,539	61.3%	$353.57	$331.72
2017-10	668	460	$385,879	$577.66	$329,346	$6,871	$56,379	$392,597	101.7%	$587.72	$356.48
2017-11	666	461	$384,448	$577.25	$158,350	$6,797	$55,436	$220,583	57.4%	$331.21	$354.04
2017-12	661	460	$383,251	$579.80	$91,854	$6,769	$37,330	$135,952	35.5%	$205.68	$341.57
2018-01	671	464	$294,914	$439.51	$139,218	$10,043	$58,132	$207,392	70.3%	$309.08	$350.28
2018-02	678	475	$378,609	$558.42	$143,214	$10,430	$50,365	$204,008	53.9%	$300.90	$323.76
2018-03	673	473	$376,435	$559.34	$220,094	$10,193	$67,097	$297,383	79.0%	$441.88	$335.98
2018-04	671	469	$373,661	$556.87	$199,301	$10,145	$67,640	$277,086	74.2%	$412.94	$351.01
2018-05	676	472	$377,179	$557.96	$291,364	$10,249	$46,916	$348,529	92.4%	$515.58	$366.90
2018-06	681	475	$381,329	$559.95	$178,508	$10,368	$39,510	$228,386	59.9%	$335.37	$367.34
2018-07	691	483	$384,894	$557.01	$181,083	$10,472	$64,798	$256,354	66.6%	$370.99	$375.12
2018-08	694	488	$387,766	$558.74	$220,312	$10,546	$61,180	$292,038	75.3%	$420.80	$382.37
2018-09	670	479	$378,378	$564.74	$182,798	$10,190	$61,474	$254,462	67.3%	$379.79	$384.54
2018-10	660	474	$372,340	$564.15	$255,564	$10,029	$49,042	$314,635	84.5%	$476.72	$375.29
2018-11	656	472	$370,069	$564.13	$197,934	$9,987	$72,387	$280,308	75.7%	$427.30	$383.14
2018-12	654	469	$368,227	$563.04	$499,232	$9,957	$72,170	$581,359	157.9%	$888.93	$438.63
Total by Experience Period											
Current Period	8,075	5,693	$4,443,801		$2,708,621	$122,609	$710,711	$3,541,941	79.7%	$438.63	
Prior Period	8,474	5,787	$4,827,182		$2,062,196	$93,790	$792,904	$2,948,891	61.1%	$347.99	
Average Membership/PMPM Premium and Payments by Experience Period											
Current Period	673	474	$550.32		$335.43	$15.18	$88.01	$438.63			
Prior Period	404	276	$569.65		$243.36	$11.07	$93.57	$347.99			
% Change											
Current Period vs Prior Period	66.8%	72.2%	(3.4%)		37.8%	37.2%	(5.9%)	26.0%			

The following grid shows detail of the main Summary Grid. If you have not requested to Add More Details to this Report, this grid will be a duplicate of the main Summary Grid. If you have requested to Add More Details to this Report, this grid will represent a detail breakout of the main Summary Grid.

Year/Month	Members	Subscribers	Premium	Premium PMPM	Medical Payments	Capitation Payments	Managed Pharmacy Payments	Total Payments	Claims to Premium Ratio	Total Payments PMPM	12 Month Rolling Average PMPM
2016-04	47	30	$32,083	$682.63	$9,664	$1,203	$12,716	$23,583	73.5%	$501.78	
2016-05	47	30	$32,083	$682.63	$6,586	$1,203	$13,214	$21,002	65.5%	$446.86	
2016-06	47	30	$32,083	$682.63	$3,297	$1,203	$13,237	$17,737	55.3%	$377.39	
2016-07	46	30	$31,135	$676.86	$1,186	$1,177	$9,260	$11,623	37.3%	$252.68	
2016-08	46	30	$31,135	$676.86	$17,139	$1,177	$16,382	$34,698	111.4%	$754.31	
2016-09	46	30	$31,135	$676.86	$19,560	$1,177	$13,704	$34,442	110.6%	$748.73	
2016-10	46	30	$31,135	$676.86	$2,834	$1,177	$13,383	$17,394	55.9%	$378.14	
2016-11	46	30	$31,135	$676.86	$3,210	$1,177	$13,279	$17,667	56.7%	$384.06	
2016-12	46	30	$31,135	$676.86	$1,420	$1,177	$16,097	$18,694	60.0%	$406.40	
2017-01	680	458	$292,526	$430.18	$95,485	$7,050	$37,836	$140,370	48.0%	$206.43	
2017-02	673	458	$388,887	$577.84	$364,384	$6,974	$44,481	$415,839	106.9%	$617.89	
2017-03	673	457	$388,158	$576.76	$122,290	$7,003	$69,648	$198,941	51.3%	$295.60	$389.68
2017-04	676	457	$386,443	$571.66	$82,219	$6,966	$68,647	$157,833	40.8%	$233.48	$353.59
2017-05	680	462	$389,474	$572.76	$120,523	$7,013	$94,549	$222,085	57.0%	$326.60	$347.46
2017-06	676	464	$388,795	$575.14	$140,677	$6,994	$75,382	$223,053	57.4%	$329.96	$344.40
2017-07	667	459	$384,870	$577.02	$141,909	$6,918	$35,928	$184,756	48.0%	$277.00	$336.18
2017-08	668	460	$385,510	$577.11	$175,669	$6,890	$40,943	$223,501	58.0%	$334.58	$332.54
2017-09	669	461	$385,879	$576.80	$174,594	$6,871	$55,074	$236,539	61.3%	$353.57	$331.72
2017-10	668	460	$385,879	$577.66	$329,346	$6,871	$56,379	$392,597	101.7%	$587.72	$356.48
2017-11	666	461	$384,448	$577.25	$158,350	$6,797	$55,436	$220,583	57.4%	$331.21	$354.04
2017-12	661	460	$383,251	$579.80	$91,854	$6,769	$37,330	$135,952	35.5%	$205.68	$341.57
2018-01	671	464	$294,914	$439.51	$139,218	$10,043	$58,132	$207,392	70.3%	$309.08	$350.28
2018-02	678	475	$378,609	$558.42	$143,214	$10,430	$50,365	$204,008	53.9%	$300.90	$323.76
2018-03	673	473	$376,435	$559.34	$220,094	$10,193	$67,097	$297,383	79.0%	$441.88	$335.98
2018-04	671	469	$373,661	$556.87	$199,301	$10,145	$67,640	$277,086	74.2%	$412.94	$351.01
2018-05	676	472	$377,179	$557.96	$291,364	$10,249	$46,916	$348,529	92.4%	$515.58	$366.90
2018-06	681	475	$381,329	$559.95	$178,508	$10,368	$39,510	$228,386	59.9%	$335.37	$367.34
2018-07	691	483	$384,894	$557.01	$181,083	$10,472	$64,798	$256,354	66.6%	$370.99	$375.12
2018-08	694	488	$387,766	$558.74	$220,312	$10,546	$61,180	$292,038	75.3%	$420.80	$382.37
2018-09	670	479	$378,378	$564.74	$182,798	$10,190	$61,474	$254,462	67.3%	$379.79	$384.54
2018-10	660	474	$372,340	$564.15	$255,564	$10,029	$49,042	$314,635	84.5%	$476.72	$375.29
2018-11	656	472	$370,069	$564.13	$197,934	$9,987	$72,387	$280,308	75.7%	$427.30	$383.14
2018-12	654	469	$368,227	$563.04	$499,232	$9,957	$72,170	$581,359	157.9%	$888.93	$438.63
Total by Experience Period											
Current Period	8,075	5,693	$4,443,801		$2,708,621	$122,609	$710,711	$3,541,941	79.7%	$438.63	
Prior Period	8,474	5,787	$4,827,182		$2,062,196	$93,790	$792,904	$2,948,891	61.1%	$347.99	
Average Membership/PMPM Premium and Payments by Experience Period											
Current Period	673	474	$550.32		$335.43	$15.18	$88.01	$438.63			
Prior Period	404	276	$569.65		$243.36	$11.07	$93.57	$347.99			
% Change											
Current Period vs Prior Period	66.8%	72.2%	(3.4%)		37.8%	37.2%	(5.9%)	26.0%			

Attachment D

8/30/18

UnitedHealthcare

High Dollar Claim Diagnosis Report

Customer Name: CITY OF NORTH MIAMI
Medical Policy: 00706725
Claim Incurral Dates: 05/01/17 to 04/30/18
Renewal Date: January 1, 2019

NOTE: This Large Loss Report is only to be released after Contracts has received all signed documentation.

Claimant 1		Claimant 2	
Paid Amount:	$158,980	Paid Amount:	$120,435
Status:	Open	Status:	Open
Diagnosis:	Tongue cancer	Diagnosis:	Psoriasis, Diabetes

Claimant 3		Claimant 4	
Paid Amount:	$111,725	Paid Amount:	$80,112
Status:	Open	Status:	Open
Diagnosis:	occlusion and stenosis of artery	Diagnosis:	common immune variable disorder

Claimant 5		Claimant 6	
Paid Amount:	$64,429	Paid Amount:	$60,217
Status:	Open	Status:	Open
Diagnosis:	Rheumatoid arthritis	Diagnosis:	Other

Claimant 7		Claimant 8	
Paid Amount:		Paid Amount:	
Status:		Status:	
Diagnosis:		Diagnosis:	

Claimant 9		Claimant 10	
Paid Amount:		Paid Amount:	
Status:		Status:	
Diagnosis:		Diagnosis:	

UnitedHealthcare

High Dollar Claim Diagnosis Report

Customer Name: CITY OF NORTH MIAMI
Medical Policy: 00706725
Claim Incurral Dates: 06/01/16 to 05/31/17
Renewal Date: January 1, 2018

NOTE: This Large Loss Report is only to be released after Contracts has received all signed documentation.

Claimant 1 Paid Amount: $79,423 Status: Open Diagnosis: common immune variable disorder	**Claimant 2** Paid Amount: $73,783 Status: Closed Diagnosis: LEIOMYOMA,PREGNANCY
Claimant 3 Paid Amount: $47,586 Status: Open Diagnosis: Other	**Claimant 4** Paid Amount: $63,245 Status: Open Diagnosis: chronic Myeloid leukemia
Claimant 5 Paid Amount: $63,767 Status: Open Diagnosis: psoriasis	**Claimant 6** Paid Amount: $61,393 Status: Open Diagnosis: Other
Claimant 7 Paid Amount: $51,759 Status: Open Diagnosis: rheumatoid arthritis	**Claimant 8** Paid Amount: $76,599 Status: Open Diagnosis: CHRONIC HEP C
Claimant 9 Paid Amount: Status: Diagnosis:	**Claimant 10** Paid Amount: Status: Diagnosis:

Attachment E

F0S4 M2
15/25/250/0%
Direct Access
NEIGHBORHOOD HEALTH PARTNERSHIP, Inc.
HMO
SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to the important advantages of Neighborhood Health Partnership, Inc. (NHP).

The Summary of Benefits, although a helpful tool, is only a summary. Always refer to your Handbook for a full explanation of your coverage or call Customer Services at the phone numbers on your health plan ID Card when you have a question about your plan. In the event of a conflict between this Summary of Benefits and the Handbook, the Handbook will control.

Services must be provided by health care providers which have contracts with NHP, referred to as "Network Providers," "Network Physicians" or "Network Hospitals," unless in an Emergency or with prior authorization by NHP.

Features	**Please note: if your Plan has a deductible, the deductible must be satisfied unless otherwise specified. You are also responsible for any deductibles, copayments and/or coinsurance listed below.**
Deductible	$250 per member, and/or $500 per family, whichever comes first. Individual deductible amounts will count toward the family deductible. However, an individual will not have to pay more than the individual deductible amount. Any deductible is on a calendar year deductible.
Out of Pocket Maximum	The limit which you and your eligible family members must pay in copayments (including pharmacy copayments) and coinsurance per calendar year is $3,000 per member and $6,000 per family. Individual Out of Pocket Maximum amounts will count toward the family Out of Pocket Maximum. However, an individual will not have to pay more than the individual Out of Pocket Maximum amount. Out of Pocket Maximum includes the Deductible. Out of Pocket Maximum includes amounts paid toward Pharmacy coinsurance.

Primary Care

Your PCP is responsible for coordinating all your health care services, including referrals to Specialists. Your PCP or Physician Specialist must obtain Prior-Authorization for designated services including, but not limited to, all inpatient care, outpatient surgical procedures, durable medical equipment (DME), home health services, home infusion, hospice care, rehabilitation, skilled nursing facility, and transplant services.

Referrals

Your PCP is responsible for coordinating all referrals to specialists, except for the following specialties which you may access directly:

- Podiatry
- Chiropractic
- Dermatology (first 5 visits per calendar year). Additional visits require referrals.
- Gynecology

Note: If your Employer purchased a Direct Access Rider, you may see a Specialist without a referral from your PCP. Please refer to your health plan ID Card or call Customer Service to verify the need to obtain a referral to a Specialist. Even when the Plan includes a Direct Access Rider, you must select a PCP or NHP will assign one to you.

YOUR NHP PLAN COVERAGE

IMPORTANT NOTICE:

Unless otherwise stated, care, services or treatment not managed by your Primary Care Physician, not Medically Necessary, or not Prior Authorized by NHP are not Covered Services. Services must be provided by Network Providers, except when Prior Authorized or in the case of an Emergency Medical Condition.

You must check your Handbook for further details relating to your coverage.

Services & Supplies	Your Responsibility for HMO Benefits
Allergy Testing	$15 copayment per visit
Ambulance *(Non-emergency transportation must be authorized in advance by NHP.)*	0%, deductible does not apply in emergency situations or when authorized by NHP to transfer you to a NHP facility.
Applied Behavioral Analysis *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $25 copayment per visit PCP referral not required. ***Inpatient:*** 0% after deductible
Autism Spectrum Disorder	Covered as any other eligible service, based on place of service.

Services & Supplies	Your Responsibility for HMO Benefits
Bones or Joints of the Jaw and Facial Region	Covered as any other eligible service, based on place of service.
Chiropractic Services	$15 copayment per visit Limited to 20 visits per calendar year, PCP referral not required.
Dermatology	$25 copayment per visit PCP referral not required for 5 visits per calendar year; further visits require PCP referral.
Diabetes	$25 copayment per visit Services include outpatient self management training and educational services.
Durable Medical Equipment (DME) and disposable medical supplies, including breast pumps	0%, after deductible
Emergency Room Services	$350 copayment per visit Any deductible and/or copayment for the emergency room is waived if the patient is admitted to the hospital.
Enteral Formula	0%, after deductible
Family Planning	Covered as any other eligible service, based on place of service. Limited to surgical sterilization, implantable contraceptives and intrauterine birth control devices.
Gynecology	$25 copayment per visit PCP referral is not required.
Hearing Aids	0%, after deductible Limited to $2,500 per year and to a single purchase (including repair/replacement) every three years.
Hearing Exams *(children through age 21)*	No copayment when performed by PCP to determine need for hearing correction. Limited to one exam per calendar year.
Home Health Services	0%, after deductible Limited to 60 visits per calendar year. Custodial care is not covered.
Home Infusion Services	0%, after deductible Limited to 60 visits per calendar year.

Services & Supplies	Your Responsibility for HMO Benefits
Hospice Care	0%, after deductible
Hospital Facility Care	***Inpatient:*** $500 copayment per admission ***Outpatient Facility - Surgical Procedure:*** 0%, after deductible
Minor Diagnostic/X-Ray and Laboratory Services	0%, deductible does not apply
Major Diagnostic Services, including CT, MRI, MRA, PET Scans and Nuclear Imaging	$200 copay, 0%, deductible does not apply
Mammography Screening	No copayment and not subject to any deductible.
Mastectomy	Covered as any other eligible service, based on place of service.
Maternity Care, including pre- and post-natal care and delivery* Physician Office Services include one OB ultrasound between weeks 13 and 24 of pregnancy.	Covered as any other eligible service, based on place of service. Note: any required office visit copayment applies only to the initial visit.
Mental Health *(Services must be provided by NHP's behavioral health network)*	***Outpatient*****:** $25 copayment per visit PCP referral not required. ***Partial Hospitalization***: 0%, after deductible ***Inpatient:*** 0% after deductible
Neurobiological Disorder Services – Autism Spectrum Disorder *(Services must be provided by NHP's behavioral health network)*	***Outpatient*****:** $25 copayment per visit PCP referral not required. ***Partial Hospitalization***: 0%, after deductible ***Inpatient:*** 0% after deductible
Newborn Children* (birth – 30 days)	Covered as any other eligible service, based on place of service when enrolled timely.

Services & Supplies	Your Responsibility for HMO Benefits
Organ Transplant Inpatient Services	Covered as any other eligible service, based on place of service. Must be Prior Authorized by NHP Medical Director or designee.
Osteoporosis	Covered as any other eligible service, based on place of service. Limited to diagnosis and treatment of high-risk individuals.
Outpatient Therapies, including Habilitative Services	$25 copayment per visit Limited to 20 visits per calendar year per type of therapy, except 36 visits for cardiac therapy. Pulmonary therapy visits are not limited.
Physical Rehabilitation – Inpatient Care	0%, after deductible Limited to 60 days per calendar year for restorative physical therapy.
Physician Services	0%, after deductible for inpatient care or outpatient surgical services when performed in an Inpatient setting or an Outpatient Facility.
Podiatry	$25 copayment per visit PCP referral not required.
Preventive Health Services	No Copayment and not subject to any Deductible.
Primary Care Physician (PCP)	$15 copayment per visit Only applies to your designated PCP.
Prosthetic Devices	0%, after deductible
Skilled Nursing Facility	0%, after deductible Limited to 120 days per calendar year; custodial care is not covered.
Specialist Office Visits	$25 copayment per visit PCP referral required except as noted above.
Sterilization	Covered as any other eligible service, based on place of service. Reversals are not covered.
Substance Use Disorders *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $25 copayment per visit PCP referral not required. ***Partial Hospitalization***: 0%, after deductible ***Inpatient:*** 0% after deductible

Services & Supplies	Your Responsibility for HMO Benefits
Therapeutic Treatments - Outpatient	0%, after deductible
Urgent Care Center	$35 copayment per visit
Vision Screening *(children through age 21)*	No copayment when performed by PCP. Deductible does not apply. Limited to services necessary to determine need for vision correction and to one exam per calendar year.

* For coverage to begin at the date of birth for newborn children, a completed and signed enrollment form must be received by NHP. When received within 30 days of birth; no additional premium will be charged for this 30 day period. When notice is received within 60 days from the date of birth, premium will be charged from the date of birth. If the enrollment form is not received within 60 days of birth, the newborn child will be considered a late enrollee. You must enroll your newborn within these time periods regardless of whether your coverage is family coverage.

Your Handbook has a description of benefits, including any limitations and exclusions.

You have coverage for Prescription Drugs only if your Employer/Group has elected to obtain a Prescription Drug Rider.

UnitedHealthcare®
Neighborhood Health Partnership

DIRECT ACCESS RIDER

As of the Effective Date, and notwithstanding anything in the Group Service Agreement ("Agreement") to the contrary, the following Direct Access Rider is hereby made a part of the Agreement if elected by the Group and such election is evidenced in the Group's Application for Group Service Agreement. The terms used in this Rider shall have the same meaning ascribed thereto or used in the Agreement, unless otherwise stated herein.

DIRECT ACCESS PROGRAM

A Member with a Direct Access Rider has the right to elect to visit an NHP Specialist without a referral from the Primary Care Physician or Plan ("Direct Access Visit(s)"). Direct Access Visits are subject to the terms and conditions of the Agreement and this Direct Access Rider. All services and treatment rendered to the Member by a NHP Specialist during or in connection with a Direct Access Visit are subject to NHP's Utilization Review (UR) requirements and the Agreement, except as may be stated otherwise in this Rider. A Direct Access Visit includes services and treatment received from an NHP Specialist, so long as such services do not require pre-certification from NHP. Those services which require pre-certification under the Plan's UR requirements require pre-certification on a Direct Access Visit.

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.

Nicholas J. Zaffiris
CEO
South Florida Health Plans

10/45/70

Prescription Drug Benefit

SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to your prescription drug benefits at Neighborhood Health Partnership (NHP) HMO. You only have a prescription drug benefit if your group elected to purchase this coverage.

The Neighborhood Health Partnership (NHP) group plans include a prescription drug benefit that features a tiered structure. This offers you more flexibility when making decisions about your prescription drug purchases.

COPAYMENT PER PRESCRIPTION ORDER OR REFILL: Your Copayment is determined by the tier NHP has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.mynhp.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. All prescription drugs must be obtained from a Plan Retail Network Pharmacy or Plan Home Delivery Network Pharmacy and must be medically necessary for the care and treatment of an illness or injury.

Annual Drug Deductible	
Individual Deductible	No Deductible
Family Deductible	No Deductible

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

Tier Level	Retail Up to 31-day supply	[1]Mail Order Up to 90-day supply
	Network	**Network**
Tier 1	$10	$20
Tier 1 Specialty	$10	Not Covered[2]
Tier 2	$45	$90
Tier 2 Specialty	$125	Not Covered[2]
Tier 3	$70	$140
Tier 3 Specialty	$250	Not Covered[2]
Growth Hormone Therapy	30% of the Prescription Drug Cost.	

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Neighborhood Health Partnership

HM33660N 1/16
Rx Summary NH4
213-8481

10/45/70

[1]Only certain Prescription Drug Products are available through mail order; please visit www.mynhp.com or call Customer Care at the telephone number on the back of your ID card for more information.

[2]Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

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RETAIL NETWORK PHARMACY: Prescription drugs may be dispensed up to a 30-day supply by a retail Plan pharmacy. Oral contraceptives may be dispensed for up to three cycles (upon payment of three copayments).

HOME DELIVERY NETWORK PHARMACY: Prescription drugs may be dispensed up to a 90-day supply by mail-order pharmacy.

UTILIZATION REVIEW

Drug utilization review and clinical review programs are used to monitor the dosage and treatment patterns for Members covered under this Agreement. Under these programs, the Plan may limit or otherwise restrict the quantity or type of drug for which the Plan will provide a benefit based upon the cost of the drug prescribed by your Provider, clinical indications and other factors. Drugs that are subject to utilization review programs are not Covered Prescription Drugs unless the requirements of the Plan's utilization review and/or clinical programs, and all of the other terms and conditions set forth in this Agreement are met. Drugs that are subject to utilization review and clinical review programs always require the Plan's prior authorization before they will be covered. The list of drugs that require prior authorization may be amended by the Plan from time to time.

Your Prescription Rider lists the exclusions, limitations and restrictions which apply.

The Summary of Benefits, although a helpful tool, is only a summary. If you have specific questions about pharmacy management procedures or whether a specific drug is covered, please call our Customer Service Department at 1-877-972-8845 or 711 for the hearing impaired. Always refer to your Prescription Drug Rider for a more-detailed explanation of your drug coverage.

UnitedHealthcare®

Benefit Summary

Florida - Choice
Consumer - Plan AHQ6 M1

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plan?

Use our national network to save money.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network.

> **Save money by staying in our network.** If you don't use the network, you'll have to pay for all of the costs.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choice** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$15	$2,000	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare of Florida, Inc.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Your cost if you use Network Benefits

Deductible

What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	$2,000 per year
Medical Deductible - Family	$4,000 per year

Out-of-Pocket Limit

What is an out-of-pocket limit?

The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$3,000 per year
Out-of-Pocket Limit - Family	$6,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits
Ambulance Services - Emergency and Non-Emergency	
Transportation cost of a newborn to the nearest appropriate facility for treatment are covered.	You pay nothing, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder	
Note: The visit limits specified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder.	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Bones or Joints of the Jaw and Facial Region	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Cleft Lip/Cleft Palate Treatment	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Clinical Trials	
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries	
	You pay nothing, after the medical deductible has been met.
Dental Services - Accident Only	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Anesthesia and Hospitalization	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Diabetes Services	
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.
Durable Medical Equipment	
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	You pay nothing, after the medical deductible has been met.
Emergency Health Services - Outpatient	
	$150 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Enteral Formulas	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Hearing Aids	
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.
Home Health Care	
Limited to 60 visits per year.	You pay nothing, after the medical deductible has been met.
Hospice Care	
	You pay nothing, after the medical deductible has been met.
Hospital - Inpatient Stay	
	You pay nothing, after the medical deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient	
	You pay nothing. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	$250 copay, deductible does not apply.
Mental Health Services	
Inpatient:	You pay nothing, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.
Neurobiological Disorders – Autism Spectrum Disorder Services	
Inpatient:	You pay nothing, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.
Osteoporosis Treatment	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies	
Limited to $2,500 per year.	You pay nothing, after the medical deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services	
	You pay nothing, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury	
Primary Physician Office Visit	Covered persons less than age 19: You pay nothing. A deductible does not apply. All other Covered Persons: $15 co-pay per visit. A deductible does not apply.
Specialist Physician Office Visit	$30 co-pay per visit. A deductible does not apply.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health service is provided.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.	
Prosthetic Devices	
Limited to a single purchase of each type of prosthetic device every 3 years.	You pay nothing, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health service is provided.
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment	
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 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. 20 visits of manipulative treatments.	$15 co-pay per visit. A deductible does not apply.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 60 days per year.	You pay nothing, after the medical deductible has been met.
Substance Use Disorder Services	
Inpatient:	You pay nothing, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.
Surgery - Outpatient	
	You pay nothing, after the medical deductible has been met.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.
Transplantation Services	
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Urgent Care Center Services	
	$35 co-pay per visit. A deductible does not apply.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.	
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$15 co-pay per visit. A deductible does not apply.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, 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 Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. 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 Contract, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. 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 Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: 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 aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. 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 Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. 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. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating 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 and paraphilic disorder. 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 disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities and Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Neurobiological Disorders – Autism Spectrum Disorder

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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. Intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does ot apply to Benefits described under Enteral Formulas in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high

dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. 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. 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 breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, 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. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

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 Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. 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. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.This exclusion does not apply to Benefits described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region in Section 1 of the COC. 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. This exclusion does not apply to Benefits as described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. 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. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Services your plan does not cover (Exclusions)

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 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. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required to be paid by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. 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.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Contract.) Health services for transplants involving permanent mechanical or animal organs. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

Services your plan does not cover (Exclusions)

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance 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 provided as described under Hospice Care in Section 1 of the COC. 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 fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. 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. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Contract. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.

Services your plan does not cover (Exclusions)

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Contract when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (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 Section 1 of the COC); required to obtain or maintain a license of any type. 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. Health services received after the date your coverage under the Contract 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 Contract ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. 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 Contract. In the event an Out-of-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. 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 we 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.

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UnitedHealthcare®

Addendum to the Medical Benefit Summary

Florida Choice

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits
Gender Dysphoria	
	The amount you pay is based on where the covered health service is provided.

This Gender Dysphoria exclusion applies:
Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

This Procedures and Treatments exclusion no longer applies when Gender Dysphoria applies:
Sex transformation operations and related services.

Mental Health Services	
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.
Neurobiological Disorders – Autism Spectrum Disorder Services	
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.
Substance Use Disorder Services	
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.

This replaces the Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders exclusion sections on the Benefit Summary:
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Transitional Living services.

This 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 Certificate of Coverage (COC), Riders, and/or Amendments, these documents shall prevail. It is recommended that you review your these documents 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. **The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.**

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UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

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

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

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

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

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

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

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

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Florida

10/30/70 Plan 159

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit

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

Tier Level	Retail Up to 31-day supply	*Mail Order Up to 90-day supply
	Network	**Network**
Tier 1	**$10**	**$25**
Tier 2	**$30**	**$75**
Tier 3	**$70**	**$175**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

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Item# **Rev. Date**
213-9485 0815

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Co-payment and/or Co-insurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

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

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

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

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government (for example, Medicare).
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are paid under any workers' compensation law or other similar laws.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury. This exclusion may not apply if Benefits were purchased by the Enrolling Group. If coverage is available, those Benefits are described under Enteral Formulas in Section 1 of the COC.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.

UnitedHealthcare®

Benefit Summary

Florida - Choice Plus
Consumer - Plan AHRR M1

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$15	$1,500	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare of Florida, Inc.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible		
What is a deductible?		
The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$1,500 per year	$2,500 per year
Medical Deductible - Family	$3,000 per year	$5,000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$2,000 per year	$5,000 per year
Out-of-Pocket Limit - Family	$4,000 per year	$10,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services - Emergency and Non-Emergency		
Transportation cost of a newborn to the nearest appropriate facility for treatment are covered.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder		
Note: The visit limits specified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder.	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Bones or Joints of the Jaw and Facial Region		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Cleft Lip/Cleft Palate Treatment		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Dental Services - Accident Only		
	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Services - Anesthesia and Hospitalization		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services - Outpatient		
	$150 co-pay per visit. A deductible does not apply.	$150 co-pay per visit. A deductible does not apply.
		Notification is required if confined in an Out-of-Network Hospital.
Enteral Formulas		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Hearing Aids		
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 visits per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Hospice Care		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	$500 copay per admission, 100% after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for sleep studies.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	$250 copay medical deductible does not apply .	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Mental Health Services		
Inpatient:	$500 copay, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	$500, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Osteoporosis Treatment		
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ostomy Supplies		
Limited to $2,500 per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	Covered persons less than age 19: You pay nothing. A deductible does not apply. All other Covered Persons: $15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$30 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every 3 years.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 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. 20 visits of manipulative treatments.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Substance Use Disorder Services		
Inpatient:	$500 copay, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Surgery - Outpatient		
	$250 copay, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$35 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, 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 Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. 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 Contract, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. 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 Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: 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 aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. 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 Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. 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. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating 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 and paraphilic disorder. 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 disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities and Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Neurobiological Disorders – Autism Spectrum Disorder

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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. Intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does ot apply to Benefits described under Enteral Formulas in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high

dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. 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. 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 breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, 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. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

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 Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. 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. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.This exclusion does not apply to Benefits described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region in Section 1 of the COC. 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. This exclusion does not apply to Benefits as described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. 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. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Services your plan does not cover (Exclusions)

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 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. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required to be paid by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. 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.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Contract.) Health services for transplants involving permanent mechanical or animal organs.

Services your plan does not cover (Exclusions)

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance 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 provided as described under Hospice Care in Section 1 of the COC. 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 fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. 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. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Contract. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.

Services your plan does not cover (Exclusions)

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Contract when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (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 Section 1 of the COC); required to obtain or maintain a license of any type. 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. Health services received after the date your coverage under the Contract 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 Contract ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. 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 Contract. In the event an Out-of-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. 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 we 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.

UnitedHealthcare®

Addendum to the Medical Benefit Summary

Florida
Choice Plus

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Gender Dysphoria		
	The amount you pay is based on where the covered health service is provided. *Prior Authorization is required for certain services.*	

This Gender Dysphoria exclusion applies:
Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

This Procedures and Treatments exclusion no longer applies when Gender Dysphoria applies:
Sex transformation operations and related services.

Mental Health Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*	70% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.

Neurobiological Disorders – Autism Spectrum Disorder Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.	70% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*
Substance Use Disorder Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.	70% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*

This replaces the Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders exclusion sections on the Benefit Summary:
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Transitional Living services.

This 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 Certificate of Coverage (COC), Riders, and/or Amendments, these documents shall prevail. It is recommended that you review your these documents 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. **The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.**

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UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

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

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

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

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

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

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

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

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Florida

10/30/50 Plan 135

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Non-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network

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

Out-of-Pocket Limit does not apply Non-Network.

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 2	**$30**	**$30**	**$75**
Tier 3	**$50**	**$50**	**$125**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

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Item# **Rev. Date**
213-9491 0815

Other Important Information about your Outpatient Prescription Drug Benefits

If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

You are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Co-payment and/or Co-insurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

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

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

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

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government (for example, Medicare).
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are paid under any workers' compensation law or other similar laws.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury. This exclusion may not apply if Benefits were purchased by the Enrolling Group. If coverage is available, those Benefits are described under Enteral Formulas in Section 1 of the COC.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- A Prescription Drug Product that contains marijuana, including medical marijuana.

- Dental products, including but not limited to prescription fluoride topicals.

UnitedHealthcare®

Benefit Summary

Florida - Choice Plus
Balanced - Plan AHLP M1

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$15	$250	10%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible		
What is a deductible?		
The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$250 per year	$500 per year
Medical Deductible - Family	$500 per year	$1,000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$2,250 per year	$4,500 per year
Out-of-Pocket Limit - Family	$4,500 per year	$9,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services - Emergency and Non-Emergency		
Transportation cost of a newborn to the nearest appropriate facility for treatment are covered.	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the network medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder		
Note: The visit limits specified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Bones or Joints of the Jaw and Facial Region		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Cleft Lip/Cleft Palate Treatment		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Dental Services - Accident Only		
	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Services - Anesthesia and Hospitalization		
	10% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services - Outpatient		
	$100 co-pay per visit. A deductible does not apply.	$200 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Enteral Formulas		
	10% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Hearing Aids		
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 visits per year.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Hospice Care		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for sleep studies.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Mental Health Services		
Inpatient:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Osteoporosis Treatment		
	10% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ostomy Supplies		
Limited to $2,500 per year.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$15co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every 3 years.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 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. 20 visits of manipulative treatments.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Substance Use Disorder Services		
Inpatient:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Surgery - Outpatient		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$50 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, 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 Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. 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 Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. 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 Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: 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 aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. 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 Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. 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. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating 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 and paraphilic disorder. 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 disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities and Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Neurobiological Disorders – Autism Spectrum Disorder

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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. Intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Services your plan does not cover (Exclusions)

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does ot apply to Benefits described under Enteral Formulas in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. 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. 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 breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, 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. Wigs regardless of the reason for the hair loss.

Services your plan does not cover (Exclusions)

Procedures and Treatments

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 Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. 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. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.This exclusion does not apply to Benefits described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region in Section 1 of the COC. 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. This exclusion does not apply to Benefits as described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. 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. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

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 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. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is paid under arrangements required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. 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.

Services your plan does not cover (Exclusions)

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance 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 provided as described under Hospice Care in Section 1 of the COC. 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 fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. 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. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.

Services your plan does not cover (Exclusions)

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (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 Section 1 of the COC); required to obtain or maintain a license of any type. 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. Health services received after the date your coverage under the Policy 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 Policy ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. 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 Policy. In the event an Out-of-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/ or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. 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 we 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.

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UnitedHealthcare®

Addendum to the Medical Benefit Summary

Florida
Choice Plus

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Gender Dysphoria		
	The amount you pay is based on where the covered health service is provided. *Prior Authorization is required for certain services.*	

This Gender Dysphoria exclusion applies:
Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

This Procedures and Treatments exclusion no longer applies when Gender Dysphoria applies:
Sex transformation operations and related services.

Mental Health Services		
Partial Hospitalization/Intensive Outpatient Treatment:	90% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*	70% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.

Neurobiological Disorders – Autism Spectrum Disorder Services		
Partial Hospitalization/Intensive Outpatient Treatment:	90% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.	70% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*
Substance Use Disorder Services		
Partial Hospitalization/Intensive Outpatient Treatment:	90% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.	70% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*

This replaces the Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders exclusion sections on the Benefit Summary:
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Transitional Living services.

This 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 Certificate of Coverage (COC), Riders, and/or Amendments, these documents shall prevail. It is recommended that you review your these documents 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. **The Benefits shown here may change some of the exclusions indicated on your Benefit Summary.**

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UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

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

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

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

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

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

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

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

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Florida

10/30/50 Plan 135

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Non-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network

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

Out-of-Pocket Limit does not apply Non-Network.

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 2	**$30**	**$30**	**$75**
Tier 3	**$50**	**$50**	**$125**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

FLMRAA13516

Item#	**Rev. Date**
213-9461	0815

UnitedHealthcare Insurance Company

Other Important Information about your Outpatient Prescription Drug Benefits

If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

You are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Co-payment and/or Co-insurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

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

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

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

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government (for example, Medicare).
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are paid under any workers' compensation law or other similar laws.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.

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Attachment F

F0S4 Modified
15/25/250/0%
W/Direct Access Rider

NEIGHBORHOOD HEALTH PARTNERSHIP, Inc.
HMO
SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to the important advantages of Neighborhood Health Partnership, Inc. (NHP).

The Summary of Benefits, although a helpful tool, is only a summary. Always refer to your Handbook for a full explanation of your coverage or call Customer Services at the phone numbers on your health plan ID Card when you have a question about your plan. In the event of a conflict between this Summary of Benefits and the Handbook, the Handbook will control.

Services must be provided by health care providers which have contracts with NHP, referred to as "Network Providers," "Network Physicians" or "Network Hospitals," unless in an Emergency or with prior authorization by NHP.

Features	**Please note: if your Plan has a deductible, the deductible must be satisfied unless otherwise specified. You are also responsible for any deductibles, copayments and/or coinsurance listed below.**
Deductible	$250 per member, and/or $500 per family, whichever comes first. Individual deductible amounts will count toward the family deductible. However, an individual will not have to pay more than the individual deductible amount. Any deductible is on a calendar year deductible.
Out of Pocket Maximum	The limit which you and your eligible family members must pay in copayments and coinsurance per calendar year is $3,000 per member and $6,000 per family. Individual Out of Pocket Maximum amounts will count toward the family Out of Pocket Maximum. However, an individual will not have to pay more than the individual Out of Pocket Maximum amount. Out of Pocket Maximum includes the Deductible.

Primary Care

Your PCP is responsible for coordinating all your health care services, including referrals to Specialists. Your PCP or Physician Specialist must obtain Prior-Authorization for designated services including, but not limited to, all inpatient care, outpatient surgical procedures, durable medical equipment (DME), home health services, home infusion, hospice care, rehabilitation, skilled nursing facility, and transplant services.

Referrals

Your PCP is responsible for coordinating all referrals to specialists, except for the following specialties which you may access directly:

- Podiatry
- Chiropractic
- Dermatology (first 5 visits per year). Additional visits require referrals.
- Gynecology

Note: If your Employer purchased a Direct Access Rider, you may see a Specialist without a referral from your PCP. Please refer to your health plan ID Card or call Customer Service to verify the need to obtain a referral to a Specialist. Even when the Plan includes a Direct Access Rider, you must select a PCP or NHP will assign one to you. If you need assistance, call Customer Service.

YOUR NHP PLAN COVERAGE

IMPORTANT NOTICE:

Unless otherwise stated, care, services or treatment not managed by your Primary Care Physician, not Medically Necessary, or not Prior Authorized by NHP are not Covered Services. Services must be provided by Network Providers, except when Prior Authorized or in the case of an Emergency Medical Condition.

You must check your Handbook for further details relating to your coverage.

Services & Supplies	Your Responsibility for HMO Benefits
Allergy Testing	$15 copayment per visit
Ambulance *(Non-emergency transportation must be authorized in advance by NHP.)*	0%, deductible does not apply in emergency situations or when authorized by NHP to transfer you to a NHP facility.
Applied Behavioral Analysis *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $25 copayment per visit ***Inpatient:*** 0% after deductible
Autism Spectrum Disorder	Covered as any other eligible service, based on place of service.
Bones or Joints of the Jaw and Facial Region	Covered as any other eligible service, based on place of service.
Chiropractic Services	$15 copayment per visit Limited to 20 visits per year, PCP referral not required.
Dermatology	$25 copayment per visit PCP referral not required for 5 visits per year; further visits require PCP referral.
Diabetes	$25 copayment per visit Services include outpatient self management training and educational services.
Durable Medical Equipment (DME) and disposable medical supplies, including breast pumps	0%, after deductible
Emergency Room Services	$350 copayment per visit. Any deductible and/or copayment for the emergency room is waived if the patient is admitted to the hospital.
Enteral Formula	0%, after deductible
Family Planning	Covered as any other eligible service, based on place of service. Limited to surgical sterilization, implantable contraceptives and intrauterine birth control devices.
Gynecology	$25 copayment per visit PCP referral is not required.

Services & Supplies	Your Responsibility for HMO Benefits
Hearing Aids	0%, after deductible Limited to $2,500 per year and to a single purchase (including repair/replacement) every three years.
Hearing Exams *(children through age 19)*	No copayment when performed by PCP to determine need for hearing correction. Limited to one exam per year. Deductible does not apply.
Home Health Services	0%, after deductible Limited to 60 visits per year. Custodial care is not covered.
Home Infusion Services	0%, after deductible Limited to 60 visits per year.
Hospice Care	0%, after deductible
Hospital Facility Care	***Inpatient:*** $500 copayment per admission ***Outpatient Facility - Surgical Procedures:*** 0% after deductible
Minor Diagnostic/X-Ray and Laboratory Services	0%, deductible does not apply
Major Diagnostic Services, including CT, MRI, MRA, PET Scans and Nuclear Imaging	$200 copayment, 0% deductible does not apply.
Mammography Screening	No copayment and not subject to any deductible.
Mastectomy	Covered as any other eligible service, based on place of service.
Maternity Care, including pre-and post-natal care and delivery* Physician Office Services include one OB ultrasound between weeks 13 and 24 of pregnancy.	Covered as any other eligible service, based on place of service. Note: any required office visit copayment applies only to the initial visit.
Mental Health *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $25 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 0%, deductible does not apply ***Inpatient:*** 0% after deductible

Services & Supplies	Your Responsibility for HMO Benefits
Neurobiological Disorder Services – Autism Spectrum Disorder *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $25 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 0%, deductible does not apply ***Inpatient:*** 0% after deductible
Newborn Children* (birth – 30 days)	Covered as any other eligible service, based on place of service when enrolled timely.
Organ Transplant Inpatient Services	Covered as any other eligible service, based on place of service. Must be Prior Authorized by NHP Medical Director or designee.
Osteoporosis	Covered as any other eligible service, based on place of service. Limited to diagnosis and treatment of high-risk individuals.
Outpatient Therapies, including Habilitative Services	$0 copayment per visit Outpatient therapies (including Habilitative Services) are limited to 20 visits per year per type of therapy, except 36 visits for cardiac therapy. Pulmonary therapy visits are not limited.
Physical Rehabilitation – Inpatient Care	0%, deductible does not apply Limited to 60 days per year for restorative physical therapy.
Physician Services	0%, after deductible for inpatient care or outpatient surgical services when performed in an Inpatient setting or an Outpatient Facility.
Podiatry	$25 copayment per visit PCP referral not required.
Preventive Health Services	No Copayment and not subject to any Deductible.
Primary Care Physician (PCP)	$15 copayment per visit Only applies to your designated PCP.
Prosthetic Devices	0%, after deductible
Skilled Nursing Facility	0%, after deductible Limited to 120 days per year; custodial care is not covered.
Specialist Office Visits	$25 copayment per visit PCP referral required except as noted above.
Sterilization	Covered as any other eligible service, based on place of service. Reversals are not covered.

Services & Supplies	Your Responsibility for HMO Benefits
Substance Use Disorders *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $25 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 0%, deductible does not apply ***Inpatient:*** 0% after deductible
Therapeutic Treatments - Outpatient	0%, after deductible
Urgent Care Center	$35 copayment per visit
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	$10 copayment per visit
Vision Screening *(children through age 19)*	No copayment when performed by PCP. Deductible does not apply.

* For coverage to begin at the date of birth for newborn children, a completed and signed enrollment form must be received by NHP. When received within 30 days of birth; no additional premium will be charged for this 30 day period. When notice is received within 60 days from the date of birth, premium will be charged from the date of birth. If the enrollment form is not received within 60 days of birth, the newborn child will be considered a late enrollee. You must enroll your newborn within these time periods regardless of whether your coverage is family coverage.

Your Handbook has a description of benefits, including any limitations and exclusions.

You have coverage for Prescription Drugs only if your Employer/Group has elected to obtain a Prescription Drug Rider.

7600 Corporate Center Drive, Miami, FL 33126 / PO Box 025680, Miami, FL 33102-5680
www.myUHC.com or call Customer Services at the phone number on your ID Card.

Please call Customer Service at the number on your ID Card for assistance regarding claims, resolving a complaint or information about Benefits and coverage.

Gender Dysphoria Rider

Neighborhood Health Partnership, Inc.

This Rider to the Group Service Agreement ("GSA") is issued to the Employer and provides Benefits for the treatment of Gender Dysphoria.

Because this Rider is part of the GSA, a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Member Handbook (Handbook)* in *ARTICLE I: DEFINITIONS* and in this Rider below.

When we use the words "we," "us," and "our" in this document, we are referring to Neighborhood Health Partnership, Inc. When we use the words "you" and "your," we are referring to people who are Members as the term is defined in the *Handbook* in *ARTICLE I: DEFINTIONS*.

ARTICLE IV: MEDICAL, SURGICAL AND RELATED SERVICES

The following provision is added to the Handbook in ARTICLE IV: MEDICAL, SURGICAL AND RELATED SERVICES:

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided in a Physician's office as described in your *Handbook*.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is described in your *Handbook*.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described in the *Outpatient Prescription Drug Rider.*
  - Puberty suppressing medication is not cross-sex hormone therapy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

  Male to Female:
  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:
  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)

- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Member must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Member meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Member must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Summary of Benefits

The provision below for Gender Dysphoria is added to the Summary of Benefits.

Covered Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Gender Dysphoria			
	Depending upon where the Covered Service is provided, Benefits will be the same as those stated under each Covered Service category in the *Summary of Benefits* and in the *Outpatient Prescription Drug Rider.*		

ARTICLE VI: EXCLUSIONS AND LIMITATIONS

The following exclusion is added to the Handbook under ARTICLE VI: EXCLUSIONS AND LIMITATIONS:

Cosmetic Procedures, including the following Abdominoplasty, Blepharoplasty, Breast enlargement, including augmentation mammoplasty and breast implants, Body contouring, such as lipoplasty, Brow lift, Calf implants, Cheek, chin, and nose implants, Injection of fillers or neurotoxins, Face lift, forehead lift, or neck tightening, Facial bone remodeling for facial feminizations, Hair removal, Hair transplantation, Lip augmentation, Lip reduction, Liposuction, Mastopexy, Pectoral implants for chest masculinization, Rhinoplasty, Skin resurfacing, Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple), Voice modification surgery and Voice lessons and voice therapy.

ARTICLE I: DEFINITIONS

The following definition of Gender Dysphoria is added to the Handbook under ARTICLE I: DEFINITIONS:

Gender Dysphoria - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- *Diagnostic criteria for adults and adolescents:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- *Diagnostic criteria for children:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
  - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Please call Customer Service at the telephone number on your ID card for assistance regarding claims, resolving a complaint or information about Benefits and coverage. Our website www.myuhc.com also includes a health care cost estimator and information regarding plan details, such as copayments and coinsurance for various services, any required deductible and the status of your maximum out-of-pocket.

Nicholas Zaffiris, CEO

Neighborhood Health Partnership, Inc.

UnitedHealthcare®
Neighborhood Health Partnership

DIRECT ACCESS RIDER

As of the Effective Date, and notwithstanding anything in the Group Service Agreement ("Agreement") to the contrary, the following Direct Access Rider is hereby made a part of the Agreement if elected by the Group and such election is evidenced in the Group's Application for Group Service Agreement. The terms used in this Rider shall have the same meaning ascribed thereto or used in the Agreement, unless otherwise stated herein.

DIRECT ACCESS PROGRAM

A Member with a Direct Access Rider has the right to elect to visit an NHP Specialist without a referral from the Primary Care Physician or Plan ("Direct Access Visit(s)"). Direct Access Visits are subject to the terms and conditions of the Agreement and this Direct Access Rider. All services and treatment rendered to the Member by a NHP Specialist during or in connection with a Direct Access Visit are subject to NHP's Utilization Review (UR) requirements and the Agreement, except as may be stated otherwise in this Rider. A Direct Access Visit includes services and treatment received from an NHP Specialist, so long as such services do not require pre-certification from NHP. Those services which require pre-certification under the Plan's UR requirements require pre-certification on a Direct Access Visit.

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.

Nicholas J. Zaffiris
CEO
South Florida Health Plans

$10/$45/$70

NH14 Modified

SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to your prescription drug benefits at Neighborhood Health Partnership (NHP) HMO. You only have a prescription drug benefit if your group elected to purchase this coverage.

The Neighborhood Health Partnership (NHP) group plans include a prescription drug benefit that features a tiered structure. This offers you more flexibility when making decisions about your prescription drug purchases.

COPAYMENT PER PRESCRIPTION ORDER OR REFILL: Your Copayment is determined by the tier NHP has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3[or Tier 4. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. All prescription drugs must be obtained from a Plan Retail Network Pharmacy or Plan Home Delivery Network Pharmacy and must be medically necessary for the care and treatment of an illness or injury.

Annual Drug Deductible	
Individual Deductible	Deductible does not apply
Family Deductible	Deductible does not apply

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

Tier Level	Retail Up to 31-day supply	*Mail Order Up to 90-day supply
	Network	**Network**
Tier 1	$10	$20
Tier 2	$45	$90
Tier 3	$70	$140
Growth Hormone Therapy	30% of the Prescription Drug Cost.	

*Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

7600 Corporate Center Drive, Miami, FL 33126
PO Box 025680, Miami, FL 33102-5680 1-877-972-8845 www.myuhc.com

$10/$45/$70

RETAIL NETWORK PHARMACY: Prescription drugs may be dispensed up to a 30-day supply by a retail Plan pharmacy. Oral contraceptives may be dispensed for up to three cycles (upon payment of three copayments).

***HOME DELIVERY NETWORK PHARMACY**: Prescription drugs may be dispensed up to a 90-day supply by mail-order pharmacy.

UTILIZATION REVIEW

Drug utilization review and clinical review programs are used to monitor the dosage and treatment patterns for Members covered under this Agreement. Under these programs, the Plan may limit or otherwise restrict the quantity or type of drug for which the Plan will provide a benefit based upon the cost of the drug prescribed by your Provider, clinical indications and other factors. Drugs that are subject to utilization review programs are not Covered Prescription Drugs unless the requirements of the Plan's utilization review and/or clinical programs, and all of the other terms and conditions set forth in this Agreement are met. Drugs that are subject to utilization review and clinical review programs always require the Plan's prior authorization before they will be covered. The list of drugs that require prior authorization may be amended by the Plan from time to time.

Your Prescription Rider lists the exclusions, limitations and restrictions which apply.

The Summary of Benefits, although a helpful tool, is only a summary. If you have specific questions about pharmacy management procedures or whether a specific drug is covered, please call our Customer Service Department at 1-877-972-8845 or 711 for the hearing impaired. Always refer to your Prescription Drug Rider for a more-detailed explanation of your drug coverage.

F0SE Modified
25/2500/10%
W/Direct Access Rider

NEIGHBORHOOD HEALTH PARTNERSHIP, Inc.
HMO
SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to the important advantages of Neighborhood Health Partnership, Inc. (NHP).

The Summary of Benefits, although a helpful tool, is only a summary. Always refer to your Handbook for a full explanation of your coverage or call Customer Services at the phone numbers on your health plan ID Card when you have a question about your plan. In the event of a conflict between this Summary of Benefits and the Handbook, the Handbook will control.

Services must be provided by health care providers which have contracts with NHP, referred to as "Network Providers," "Network Physicians" or "Network Hospitals," unless in an Emergency or with prior authorization by NHP.

Features	**Please note: if your Plan has a deductible, the deductible must be satisfied unless otherwise specified. You are also responsible for any deductibles, copayments and/or coinsurance listed below.**
Deductible	$2,500 per member, and/or $5,000 per family, whichever comes first. Individual deductible amounts will count toward the family deductible. However, an individual will not have to pay more than the individual deductible amount. Any deductible is on calendar year basis.
Coinsurance	Benefits as defined below may be subject to a coinsurance of 10% once the calendar year deductible is met.
Out of Pocket Maximum	The limit which you and your eligible family members must pay in copayments and coinsurance per calendar year is $5,000 per member and $10,000 per family. Individual Out of Pocket Maximum amounts will count toward the family Out of Pocket Maximum. However, an individual will not have to pay more than the individual Out of Pocket Maximum amount. Out of Pocket Maximum includes the Deductible.

Primary Care

Your PCP is responsible for coordinating all your health care services, including referrals to Specialists. Your PCP or Physician Specialist must obtain Prior-Authorization for designated services including, but not limited to, all inpatient care, outpatient surgical procedures, durable medical equipment (DME), home health services, home infusion, hospice care, rehabilitation, skilled nursing facility, and transplant services.

Referrals

Your PCP is responsible for coordinating all referrals to specialists, except for the following specialties which you may access directly:

- Podiatry
- Chiropractic
- Dermatology (first 5 visits per year). Additional visits require referrals.
- Gynecology

Note: If your Employer purchased a Direct Access Rider, you may see a Specialist without a referral from your PCP. Please refer to your health plan ID Card or call Customer Service to verify the need to obtain a referral to a Specialist. Even when the Plan includes a Direct Access Rider, you must select a PCP or NHP will assign one to you. If you need assistance, call Customer Service.

YOUR NHP PLAN COVERAGE

IMPORTANT NOTICE:

Unless otherwise stated, care, services or treatment not managed by your Primary Care Physician, not Medically Necessary, or not Prior Authorized by NHP are not Covered Services. Services must be provided by Network Providers, except when Prior Authorized or in the case of an Emergency Medical Condition.

You must check your Handbook for further details relating to your coverage.

Services & Supplies	Your Responsibility for HMO Benefits
Allergy Testing	$25 copayment per visit
Ambulance *(Non-emergency transportation must be authorized in advance by NHP.)*	10% after deductible in emergency situations or when authorized by NHP to transfer you to a NHP facility.
Applied Behavioral Analysis *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $45 copayment per visit ***Inpatient:*** 10% after deductible
Autism Spectrum Disorder	Covered as any other eligible service, based on place of service.
Bones or Joints of the Jaw and Facial Region	Covered as any other eligible service, based on place of service.
Chiropractic Services	$25 copayment per visit Limited to 20 visits per year, PCP referral not required.
Dermatology	$45 copayment per visit PCP referral not required for 5 visits per year; further visits require PCP referral.
Diabetes	$45 copayment per visit Services include outpatient self management training and educational services.
Durable Medical Equipment (DME) and disposable medical supplies, including breast pumps	10% after deductible
Emergency Room Services	$350 copayment per visit. Any deductible and/or copayment for the emergency room is waived if the patient is admitted to the hospital.
Enteral Formula	10% after deductible
Family Planning	Covered as any other eligible service, based on place of service. Limited to surgical sterilization, implantable contraceptives and intrauterine birth control devices.
Gynecology	$45 copayment per visit PCP referral is not required.

Services & Supplies	Your Responsibility for HMO Benefits
Hearing Aids	10% after deductible Limited to $2,500 per year and to a single purchase (including repair/replacement) every three years.
Hearing Exams *(children through age 19)*	No copayment when performed by PCP to determine need for hearing correction. Limited to one exam per year. Deductible does not apply.
Home Health Services	10% after deductible Limited to 60 visits per year. Custodial care is not covered.
Home Infusion Services	10% after deductible Limited to 60 visits per year.
Hospice Care	10% after deductible
Hospital Facility Care	***Inpatient:*** 10% after deductible ***Outpatient Facility - Surgical Procedures:*** 10% after deductible
Minor Diagnostic/X-Ray and Laboratory Services	0%, deductible does not apply
Major Diagnostic Services, including CT, MRI, MRA, PET Scans and Nuclear Imaging	10% after deductible
Mammography Screening	No copayment and not subject to any deductible.
Mastectomy	Covered as any other eligible service, based on place of service.
Maternity Care, including pre-and post-natal care and delivery* Physician Office Services include one OB ultrasound between weeks 13 and 24 of pregnancy.	Covered as any other eligible service, based on place of service. Note: any required office visit copayment applies only to the initial visit.
Mental Health *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $45 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 10% after deductible ***Inpatient: 1***0% after deductible

Services & Supplies	Your Responsibility for HMO Benefits
Neurobiological Disorder Services – Autism Spectrum Disorder *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $45 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 10% after deductible ***Inpatient: 1***0% after deductible
Newborn Children* (birth – 30 days)	Covered as any other eligible service, based on place of service when enrolled timely.
Organ Transplant Inpatient Services	Covered as any other eligible service, based on place of service. Must be Prior Authorized by NHP Medical Director or designee.
Osteoporosis	Covered as any other eligible service, based on place of service. Limited to diagnosis and treatment of high-risk individuals.
Outpatient Therapies, including Habilitative Services	$25 copayment per visit Outpatient therapies (including Habilitative Services) are limited to 20 visits per year per type of therapy, except 36 visits for cardiac therapy. Pulmonary therapy visits are not limited.
Physical Rehabilitation – Inpatient Care	10% after deductible Limited to 60 days per year for restorative physical therapy.
Physician Services	10% after deductible for inpatient care or outpatient surgical services when performed in an Inpatient setting or an Outpatient
Podiatry	$45 copayment per visit PCP referral not required.
Preventive Health Services	No Copayment and not subject to any Deductible.
Primary Care Physician (PCP)	$25 copayment per visit Only applies to your designated PCP.
Prosthetic Devices	10% after deductible
Skilled Nursing Facility	10% after deductible Limited to 120 days per year; custodial care is not covered.
Specialist Office Visits	$45 copayment per visit PCP referral required except as noted above.
Sterilization	Covered as any other eligible service, based on place of service. Reversals are not covered.

Services & Supplies	Your Responsibility for HMO Benefits
Substance Use Disorders *(Services must be provided by NHP's behavioral health network)*	***Outpatient*:** $45 copayment per visit ***Partial Hospitalization/Intensive Outpatient Treatment:*** 10% after deductible ***Inpatient: 1***0% after deductible
Therapeutic Treatments - Outpatient	10% after deductible
Urgent Care Center	$75 copayment per visit
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.	$25 copayment per visit
Vision Screening *(children through age 19)*	No copayment when performed by PCP. Deductible does not apply.

* For coverage to begin at the date of birth for newborn children, a completed and signed enrollment form must be received by NHP. When received within 30 days of birth; no additional premium will be charged for this 30 day period. When notice is received within 60 days from the date of birth, premium will be charged from the date of birth. If the enrollment form is not received within 60 days of birth, the newborn child will be considered a late enrollee. You must enroll your newborn within these time periods regardless of whether your coverage is family coverage.

Your Handbook has a description of benefits, including any limitations and exclusions.

You have coverage for Prescription Drugs only if your Employer/Group has elected to obtain a Prescription Drug Rider.

7600 Corporate Center Drive, Miami, FL 33126 / PO Box 025680, Miami, FL 33102-5680
www.myUHC.com or call Customer Services at the phone number on your ID Card.

Please call Customer Service at the number on your ID Card for assistance regarding claims, resolving a complaint or information about Benefits and coverage.

Gender Dysphoria Rider

Neighborhood Health Partnership, Inc.

This Rider to the Group Service Agreement ("GSA") is issued to the Employer and provides Benefits for the treatment of Gender Dysphoria.

Because this Rider is part of the GSA, a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Member Handbook (Handbook)* in *ARTICLE I: DEFINITIONS* and in this Rider below.

When we use the words "we," "us," and "our" in this document, we are referring to Neighborhood Health Partnership, Inc. When we use the words "you" and "your," we are referring to people who are Members as the term is defined in the *Handbook* in *ARTICLE I: DEFINTIONS*.

ARTICLE IV: MEDICAL, SURGICAL AND RELATED SERVICES

The following provision is added to the Handbook in ARTICLE IV: MEDICAL, SURGICAL AND RELATED SERVICES:

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided in a Physician's office as described in your *Handbook*.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is described in your *Handbook*.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described in the *Outpatient Prescription Drug Rider.*
  - Puberty suppressing medication is not cross-sex hormone therapy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

  Male to Female:
  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:
  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)

- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Member must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Member meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Member must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Summary of Benefits

The provision below for Gender Dysphoria is added to the Summary of Benefits.

Covered Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Gender Dysphoria			
	Depending upon where the Covered Service is provided, Benefits will be the same as those stated under each Covered Service category in the *Summary of Benefits* and in the *Outpatient Prescription Drug Rider.*		

ARTICLE VI: EXCLUSIONS AND LIMITATIONS

The following exclusion is added to the Handbook under ARTICLE VI: EXCLUSIONS AND LIMITATIONS:

Cosmetic Procedures, including the following Abdominoplasty, Blepharoplasty, Breast enlargement, including augmentation mammoplasty and breast implants, Body contouring, such as lipoplasty, Brow lift, Calf implants, Cheek, chin, and nose implants, Injection of fillers or neurotoxins, Face lift, forehead lift, or neck tightening, Facial bone remodeling for facial feminizations, Hair removal, Hair transplantation, Lip augmentation, Lip reduction, Liposuction, Mastopexy, Pectoral implants for chest masculinization, Rhinoplasty, Skin resurfacing, Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple), Voice modification surgery and Voice lessons and voice therapy.

ARTICLE I: DEFINITIONS

The following definition of Gender Dysphoria is added to the Handbook under ARTICLE I: DEFINITIONS:

Gender Dysphoria - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- *Diagnostic criteria for adults and adolescents:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- *Diagnostic criteria for children:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
  - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Please call Customer Service at the telephone number on your ID card for assistance regarding claims, resolving a complaint or information about Benefits and coverage. Our website www.myuhc.com also includes a health care cost estimator and information regarding plan details, such as copayments and coinsurance for various services, any required deductible and the status of your maximum out-of-pocket.

Nicholas Zaffiris, CEO

Neighborhood Health Partnership, Inc.

UnitedHealthcare®
Neighborhood Health Partnership

DIRECT ACCESS RIDER

As of the Effective Date, and notwithstanding anything in the Group Service Agreement ("Agreement") to the contrary, the following Direct Access Rider is hereby made a part of the Agreement if elected by the Group and such election is evidenced in the Group's Application for Group Service Agreement. The terms used in this Rider shall have the same meaning ascribed thereto or used in the Agreement, unless otherwise stated herein.

DIRECT ACCESS PROGRAM

A Member with a Direct Access Rider has the right to elect to visit an NHP Specialist without a referral from the Primary Care Physician or Plan ("Direct Access Visit(s)"). Direct Access Visits are subject to the terms and conditions of the Agreement and this Direct Access Rider. All services and treatment rendered to the Member by a NHP Specialist during or in connection with a Direct Access Visit are subject to NHP's Utilization Review (UR) requirements and the Agreement, except as may be stated otherwise in this Rider. A Direct Access Visit includes services and treatment received from an NHP Specialist, so long as such services do not require pre-certification from NHP. Those services which require pre-certification under the Plan's UR requirements require pre-certification on a Direct Access Visit.

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.

Nicholas J. Zaffiris
CEO
South Florida Health Plans

$10/$45/$70

NH14 Modified

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Individual Deductible	Deductible does not apply
Family Deductible	Deductible does not apply

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Individual Out-of-Pocket Maximum	See Medical Benefit Summary
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$10/$45/$70

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The Summary of Benefits, although a helpful tool, is only a summary. If you have specific questions about pharmacy management procedures or whether a specific drug is covered, please call our Customer Service Department at 1-877-972-8845 or 711 for the hearing impaired. Always refer to your Prescription Drug Rider for a more-detailed explanation of your drug coverage.

UnitedHealthcare®

Benefit Summary

Florida - Choice Plus
Balanced - Plan AQON Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$15	$250	10%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible		
What is a deductible?		
The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$250 per year	$500 per year
Medical Deductible - Family	$500 per year	$1,000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$2,250 per year	$4,500 per year
Out-of-Pocket Limit - Family	$4,500 per year	$9,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services		
Emergency Transportation cost of a newborn to the nearest appropriate facility for treatment are covered.	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the network medical deductible has been met.
Non-Emergency Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder		
Note: The visit limits specified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder. The limits specified above do not include Covered Health Services under Neurobiological Disorders - Autism Spectrum Disorder Services.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Bones or Joints of the Jaw and Facial Region		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Cleft Lip/Cleft Palate Treatment		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Congenital Heart Disease (CHD) Surgeries		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Accident Only		
	10% co-insurance, after the medical deductible has been met. Prior Authorization is required.	10% co-insurance, after the network medical deductible has been met. Prior Authorization is required.
Dental Services - Anesthesia and Hospitalization		
	10% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services - Outpatient		
	$100 co-pay per visit. A deductible does not apply.	$100 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Enteral Formulas		
	10% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Gender Dysphoria		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required for certain services.
Hearing Aids		
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 visits per year.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Services		
Inpatient:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Osteoporosis Treatment		
	10% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
Limited to $2,500 per year.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every 3 years.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 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. 20 visits of manipulative treatments.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Substance Use Disorder Services		
Inpatient:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Surgery - Outpatient		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$50 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, 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 Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. 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 Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. 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 Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: 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 aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. 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 Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. 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. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

Services your plan does not cover (Exclusions)

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders

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

Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Benefits described under Enteral Formulas in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. 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. 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 breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, 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. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty 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. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. 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. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations. This exclusion does not apply to Benefits described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region in Section 1 of the COC. 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. This exclusion does not apply to Benefits as described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. 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. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

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 provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic or Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based 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.

Services your plan does not cover (Exclusions)

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. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is paid by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. 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 those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance 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 provided as described under Hospice Care in Section 1 of the COC. 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 fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. 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. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (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 Section 1 of the COC); required to obtain or maintain a license of any type. 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 non-war zones. Health services received after the date your coverage under the Policy 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 Policy ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. 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 Policy. In the event an Out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. 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 we 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.

UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare 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.

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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 others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

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

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

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

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

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UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Florida

10/30/50 Plan 135

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Non-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network

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

Out-of-Pocket Limit does not apply Non-Network and Coupons.

Benefit Plan Co-payment/Co-insurance - The amount you pay.

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 2	**$30**	**$30**	**$75**
Tier 3	**$50**	**$50**	**$125**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

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Item# **Rev. Date**
213-12106 0317

Other Important Information about your Outpatient Prescription Drug Benefits

If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

You are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Co-payment and/or Co-insurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

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

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

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program each year through the Internet at myuhc.com or by calling Customer Care at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any oral non-sedating antihistamine or antihistamine-decongestant combination.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury. This exclusion does not apply if Benefits were purchased by the Enrolling Group. If coverage is available, those Benefits are described under Enteral Formulas in Section 1 of the COC.
- Prescription Drug Products designed to adjust sleep schedule, such as for jet lag or shift work.
- Prescription Drug Products when used for sleep aids.

- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.
- A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

UnitedHealthcare®

Benefit Summary

Florida - Choice Plus
Consumer - Plan AQQJ Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$15	$1,500	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare of Florida, Inc.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible		
What is a deductible?		
The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$1,500 per year	$2,500 per year
Medical Deductible - Family	$3,000 per year	$5,000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The most you pay during a contract year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$2,000 per year	$5,000 per year
Out-of-Pocket Limit - Family	$4,000 per year	$10,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services		
Emergency Transportation cost of a newborn to the nearest appropriate facility for treatment are covered.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
Non-Emergency Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder		
Note: The visit limits specified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Bones or Joints of the Jaw and Facial Region		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Cleft Lip/Cleft Palate Treatment		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Services - Accident Only		
	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Dental Services - Anesthesia and Hospitalization		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services - Outpatient		
	$150 co-pay per visit. A deductible does not apply.	$150 co-pay per visit. A deductible does not apply.
		Notification is required if confined in an Out-of-Network Hospital.
Enteral Formulas		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Gender Dysphoria		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required for certain services.
Hearing Aids		
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 visits per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	$500 Copayment per admission, 100% after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	$250 copay , medical deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Services		
Inpatient:	$500 copayment, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	$500 copayment, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Osteoporosis Treatment		
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
Limited to $2,500 per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	Covered persons less than age 19: You pay nothing. A deductible does not apply. All other Covered Persons: $15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$30 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every 3 years.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required.
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 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. 20 visits of manipulative treatments.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Substance Use Disorder Services		
Inpatient:	$500 copayment, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Surgery - Outpatient		
	$250 copayment, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Temporomandibular Joint Services		
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$35 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, 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 Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. 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 Contract, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. 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 Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: 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 aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. 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 Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. 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. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

Services your plan does not cover (Exclusions)

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders

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

Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Benefits described under Enteral Formulas in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. 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. 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 breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, 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. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty 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. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. 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. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations. This exclusion does not apply to Benefits described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region in Section 1 of the COC. 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. This exclusion does not apply to Benefits as described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. 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. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

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 provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic or Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based 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.

Services your plan does not cover (Exclusions)

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. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is paid by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. 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 those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Contract.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance 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 provided as described under Hospice Care in Section 1 of the COC. 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 fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. 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. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Contract. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Note: These exclusions do not apply to the Physician Services, soft lenses or sclera shells for the treatment of aphakic patients or to initial glasses or contact lenses following cataract surgery. Routine vision examinations, including refractive examinations to determine the need for vision correction.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Contract when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (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 Section 1 of the COC); required to obtain or maintain a license of any type. 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 non-war zones. Health services received after the date your coverage under the Contract 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 Contract ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. 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 Contract. In the event an Out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. 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 we 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.

UnitedHealthcare of Florida, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare 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 member phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

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

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

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

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

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

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

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

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Florida

10/30/50 Plan 135

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Non-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network

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

Out-of-Pocket Limit does not apply Non-Network and Coupons.

Benefit Plan Co-payment/Co-insurance - The amount you pay.

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 2	**$30**	**$30**	**$75**
Tier 3	**$50**	**$50**	**$125**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

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213-12050 0317

Other Important Information about your Outpatient Prescription Drug Benefits

If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

You are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Co-payment and/or Co-insurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

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

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

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program each year through the Internet at myuhc.com or by calling Customer Care at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any oral non-sedating antihistamine or antihistamine-decongestant combination.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury. This exclusion does not apply if Benefits were purchased by the Enrolling Group. If coverage is available, those Benefits are described under Enteral Formulas in Section 1 of the COC.
- Prescription Drug Products designed to adjust sleep schedule, such as for jet lag or shift work.
- Prescription Drug Products when used for sleep aids.

- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.
- A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

UnitedHealthcare of Florida, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare 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 member phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

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

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

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

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

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

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

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

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

UnitedHealthcare®

Benefit Summary

Florida - Choice
Consumer - Plan AQRA Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plan?

Use our national network to save money.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network.

> **Save money by staying in our network.** If you don't use the network, you'll have to pay for all of the costs.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choice** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$15	$2,000	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare of Florida, Inc.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Your cost if you use Network Benefits

Deductible

What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	$2,000 per year
Medical Deductible - Family	$4,000 per year

Out-of-Pocket Limit

What is an out-of-pocket limit?

The most you pay during a contract year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$3,000 per year
Out-of-Pocket Limit - Family	$6,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits
Ambulance Services	
Emergency Transportation cost of a newborn to the nearest appropriate facility for treatment are covered.	You pay nothing, after the medical deductible has been met.
Non-Emergency Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	You pay nothing, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder	
Note: The visit limits specified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder.	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Bones or Joints of the Jaw and Facial Region	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Cleft Lip/Cleft Palate Treatment	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Clinical Trials	
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries	
	You pay nothing, after the medical deductible has been met.
Dental Services - Accident Only	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Anesthesia and Hospitalization	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Diabetes Services	
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.
Durable Medical Equipment	
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	You pay nothing, after the medical deductible has been met.
Emergency Health Services - Outpatient	
	$150 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Enteral Formulas	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Gender Dysphoria	
	The amount you pay is based on where the covered health service is provided.
Hearing Aids	
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.
Home Health Care	
Limited to 60 visits per year.	You pay nothing, after the medical deductible has been met.
Hospice Care	
	You pay nothing, after the medical deductible has been met.
Hospital - Inpatient Stay	
	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Lab, X-Ray and Diagnostics - Outpatient	
	You pay nothing. A deductible does not apply.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	$250 copayment, deductible does not apply.
Mental Health Services	
Inpatient:	You pay nothing, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.
Neurobiological Disorders – Autism Spectrum Disorder Services	
Inpatient:	You pay nothing, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.
Osteoporosis Treatment	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies	
Limited to $2,500 per year.	You pay nothing, after the medical deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services	
	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Physician's Office Services - Sickness and Injury	
Primary Physician Office Visit	Covered persons less than age 19: You pay nothing. A deductible does not apply. All other Covered Persons: $15 co-pay per visit. A deductible does not apply.
Specialist Physician Office Visit	$30 co-pay per visit. A deductible does not apply.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.

Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health service is provided.
Prescription Drug Benefits	

Prescription drug benefits are shown in the Prescription Drug benefit summary.

Preventive Care Services	
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.

Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.

Prosthetic Devices	
Limited to a single purchase of each type of prosthetic device every 3 years.	You pay nothing, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health service is provided.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment	
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 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. 20 visits of manipulative treatments.	$15 co-pay per visit. A deductible does not apply.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 60 days per year.	You pay nothing, after the medical deductible has been met.
Substance Use Disorder Services	
Inpatient:	You pay nothing, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.
Surgery - Outpatient	
	You pay nothing, after the medical deductible has been met.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Transplantation Services	
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Urgent Care Center Services	
	$35 co-pay per visit. A deductible does not apply.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.	
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$15 co-pay per visit. A deductible does not apply.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, 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 Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to Benefits as described under Bones or Joints of the Jaw and Facial Region and Dental Services – Anesthesia and Hospitalization in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 1 of the COC. 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 Contract, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to dental services for which Benefits are provided as described under Bones or Joints of the Jaw and Facial Region and Cleft Lip/Cleft Palate in Section 1 of the COC. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 1 of the COC. 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 Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under Cleft Lip/Cleft Palate in Section 1 of the COC.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: 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 aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Benefits as described under Diabetes Services in Section 1 of the COC. 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to medically appropriate medications prescribed for the treatment of cancer. The drug must be recognized for the treatment of that indication, and published within a standard reference compendium or recommended in medical literature. 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 Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. 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. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

Services your plan does not cover (Exclusions)

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders

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

Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Benefits described under Enteral Formulas in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. 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. 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 breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, 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. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty 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. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. 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. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations. This exclusion does not apply to Benefits described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region in Section 1 of the COC. 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. This exclusion does not apply to Benefits as described under Additional Benefits Required by Florida Law - Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. 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. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

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 provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic or Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based 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.

Services your plan does not cover (Exclusions)

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. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is paid by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. 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 those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Contract.) Health services for transplants involving permanent mechanical or animal organs. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance 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 provided as described under Hospice Care in Section 1 of the COC. 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 fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. 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. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Contract. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Note: These exclusions do not apply to the Physician Services, soft lenses or sclera shells for the treatment of aphakic patients or to initial glasses or contact lenses following cataract surgery. Routine vision examinations, including refractive examinations to determine the need for vision correction.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Contract when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (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 Section 1 of the COC); required to obtain or maintain a license of any type. 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 non-war zones. Health services received after the date your coverage under the Contract 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 Contract ended. This exclusion does not apply to health services covered under Extended Coverage for Pregnancy or Extended Coverage for Total Disability in Section 4 of the COC. 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 Contract. In the event an Out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. 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 we 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.

UnitedHealthcare of Florida, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare 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 member phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

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

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

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

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

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

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

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

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

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UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Florida

10/30/70 Plan 159

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit

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

Benefit Plan Co-payment/Co-insurance - The amount you pay.

Tier Level	Retail Up to 31-day supply	*Mail Order Up to 90-day supply
	Network	**Network**
Tier 1	**$10**	**$25**
Tier 2	**$30**	**$75**
Tier 3	**$70**	**$175**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

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Item# **Rev. Date**
213-12041 0317

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Co-payment and/or Co-insurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

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

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

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any oral non-sedating antihistamine or antihistamine-decongestant combination.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury. This exclusion does not apply if Benefits were purchased by the Enrolling Group. If coverage is available, those Benefits are described under Enteral Formulas in Section 1 of the COC.
- Prescription Drug Products designed to adjust sleep schedule, such as for jet lag or shift work.
- Prescription Drug Products when used for sleep aids.

- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.
- A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

UnitedHealthcare of Florida, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare 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 member phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

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

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

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

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

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

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

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

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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

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

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

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

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

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

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

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

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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

Attachment G

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City of North Miami
Proposed Effective Date: 01-01-2019
Aetna Health Network Only℠ - Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	$250 Individual $500 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.	
Out-of-Pocket Maximum (per calendar year)	$3,000 Individual $6,000 Family
In-network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months for members age 22 and older.	
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 exam per 12 months Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
Women's Health	Covered 100%; deductible waived
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
Routine Digital Rectal Exams / Prostate Specific Antigen Test	Covered 100%; deductible waived
Recommended for males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 50 and over. Frequency schedule applies.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

Routine Eye Exams	Covered 100%; deductible waived 1 routine exam per 24 months.
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$15 office visit copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$25 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$15 copay; deductible waived
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic Laboratory	Covered 100%; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic X-ray	Covered 100%; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic X-ray for Complex Imaging Services	$200 copay; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$35 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$350 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	$500 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100% for Physician maternity services; deductible waived; $500 copay for Facility services; deductible aived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

Outpatient Hospital	Covered 100%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	$500 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$25 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	$500 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	Covered 100%; after deductible
Substance Abuse Office Visits	$25 copay; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%; after deductible
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	Covered 100%; after deductible Limited to 120 days; per calendar year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered 100%; after deductible Limited to 60 visits; per calendar year
Coverage includes nutritional counseling and services of a medical social worker. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	Covered 100%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered 100%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Short-Term Rehabilitation	$15 per visit; deductible waived Limited to 60 visits; per calendar year
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$15 per visit; deductible waived Limited to 20 visits; per calendar year
Direct access to participating providers without a referral.	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	$15 per visit; deductible waived
Autism Occupational Therapy	$15 per visit; deductible waived
Autism Speech Therapy	$15 per visit; deductible waived
Durable Medical Equipment	Covered 100%; after deductible
Prosthetics	Covered 100%; after deductible
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.

PLAN DESIGN & BENEFITS
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Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	Covered 100%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Covered 100%; after deductible
Transplants	$500 copay; deductible waived Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered

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Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary
Preferred Generic Drugs	
Retail	$10 copay
Mail Order	$20 copay
Preferred Brand-Name Drugs	
Retail	$45 copay
Mail Order	$90 copay
Non-Preferred Generic and Brand-Name Drugs	
Retail	$70 copay
Mail Order	$140 copay
Pharmacy Day Supply and Requirements	
Retail	Up to a 31 day supply from Aetna National Network
Mail Order	A 32-90 day supply from Aetna Rx Home Delivery®.
Value Plus Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Value Plus Pre-certification included
Value Plus Step Therapy included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
One transition fill allowed within 90 days of member's effective date
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits plans contain exclusions and limitations.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.

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City of North Miami
Proposed Effective Date: 01-01-2019
Aetna Health Network Only℠ - Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	$2,500 Individual $5,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.	
Out-of-Pocket Maximum (per calendar year)	$5,000 Individual $10,000 Family
In-network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months for members age 22 and older.	
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 exam per 12 months Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%; deductible waived
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
Women's Health	Covered 100%; deductible waived
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
Routine Digital Rectal Exams / Prostate Specific Antigen Test	Covered 100%; deductible waived
Recommended for males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 50 and over. Frequency schedule applies.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

Routine Eye Exams	Covered 100%; deductible waived 1 routine exam per 24 months.
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$25 office visit copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$45 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$25 copay; deductible waived
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic Laboratory	Covered 100%; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic X-ray	Covered 100%; deductible waived
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
Diagnostic X-ray for Complex Imaging Services	10%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$75 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$350 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	10%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100% for Physician maternity services; after deductible; 10% for Facility services; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

Outpatient Hospital	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$45 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	10%; after deductible
Substance Abuse Office Visits	$45 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	10%; after deductible Limited to 120 days; per calendar year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	10%; after deductible Limited to 60 visits; per calendar year
Coverage includes nutritional counseling and services of a medical social worker. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	10%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Short-Term Rehabilitation	$25 per visit; deductible waived Limited to 36 visits; per calendar year
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$25 per visit; deductible waived Limited to 20 visits; per calendar year
Direct access to participating providers without a referral.	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health Other Services
Covered same as any other Outpatient Mental Health Other Services benefit	
Autism Physical Therapy	$25 per visit; deductible waived
Autism Occupational Therapy	$25 per visit; deductible waived
Autism Speech Therapy	$25 per visit; deductible waived
Durable Medical Equipment	10%; after deductible
Prosthetics	10%; after deductible
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.

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PROVIDED BY AETNA HEALTH INC. - FULL RISK

Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	10%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	10%; after deductible
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered

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Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary
Preferred Generic Drugs	
Retail	$10 copay
Mail Order	$20 copay
Preferred Brand-Name Drugs	
Retail	$45 copay
Mail Order	$90 copay
Non-Preferred Generic and Brand-Name Drugs	
Retail	$70 copay
Mail Order	$140 copay
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply from Aetna National Network
Mail Order	A 31-90 day supply from Aetna Rx Home Delivery®.
Value Plus Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Value Plus Pre-certification included
Value Plus Step Therapy included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
One transition fill allowed within 90 days of member's effective date
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits plans contain exclusions and limitations.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

PLAN DESIGN & BENEFITS
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The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

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City of North Miami
Proposed Effective Date: 01-01-2019
Aetna Health Network Option℠ - Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. - FULL RISK

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$2,500 Individual $5,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Applicable covered expenses accumulate separately toward the in-network and out-of-network providers Deductible. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Out-of-Pocket Maximum (per calendar year)	$2,000 Individual $4,000 Family	$5,000 Individual $10,000 Family
All applicable covered expenses accumulate separately toward the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductible. Penalty amounts do not apply. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%; deductible waived	Not Covered
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	30%; deductible waived
Routine Gynecological Care Exams 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%; deductible waived	Not Covered
Routine Mammograms Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	Covered 100%; deductible waived	30%; after deductible

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Women's Health	Covered 100%; deductible waived	Covered according to standard claim practice.
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%; deductible waived	Not Covered
Colorectal Cancer Screening Recommended: For all members age 50 and over. Frequency schedule applies.	Covered 100%; deductible waived	Not Covered
Routine Eye Exams	Covered 100%; deductible waived 1 routine exam per 24 months.	30%; after deductible 1 routine exam per 24 months.
Routine Hearing Screening	Covered 100%; deductible waived	Not Covered
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Physician Visits Includes services of an internist, general physician, family practitioner or pediatrician.	$15 office visit copay; deductible waived	30%; after deductible
Specialist Office Visits	$30 copay; deductible waived	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	$15 copay; deductible waived	30%; after deductible
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 100%; deductible waived	30%; after deductible
Diagnostic X-ray If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	Covered 100%; deductible waived	30%; after deductible
Diagnostic X-ray for Complex Imaging Services If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	$250 copay; deductible waived	30%; after deductible

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City of North Miami
Proposed Effective Date: 01-01-2019
Aetna Health Network Option℠ - Florida

PLAN DESIGN & BENEFITS
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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Provider	$35 copay; deductible waived	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$150 copay; deductible waived	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; after deductible	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	$500 copay; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100% for Physician maternity services; deductible waived; $500 copay for Facility Services; after deductible	30% for Physician Maternity Services; after deductible; 30% for Facility Services; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital	Covered 100%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$500 copay; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$30 copay; deductible waived	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; after deductible	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	$500 copay; after deductible	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	$500 copay; after deductible	30% per admission; after deductible
Substance Abuse Office Visits	$30 copay; deductible waived	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; after deductible	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	$500 copay; after deductible Limited to 60 days; per calendar year	30% per admission; after deductible Limited to 60 days; per calendar year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible Limited to 60 visits; per calendar year	30%; after deductible Limited to 60 visits; per calendar year
Coverage includes nutritional counseling and services of a medical social worker. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100%; deductible waived	30% per admission; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; deductible waived	30% per visit; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy	$15 per visit; deductible waived Limited to 60 visits; per calendar year	30% per visit; after deductible Limited to 30 visits; per calendar year
Spinal Manipulation Therapy Direct access to participating providers without a referral.	$15 per visit; deductible waived Limited to 20 visits; per calendar year	30%; after deductible Limited to 20 visits; per calendar year
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	$15 per visit; deductible waived	30%; after deductible
Autism Occupational Therapy	$15 per visit; deductible waived	30%; after deductible
Autism Speech Therapy	$15 per visit; deductible waived	30%; after deductible
Durable Medical Equipment	Covered 100%; after deductible	30%; after deductible (must precertify if over $1,500)
Prosthetics	Covered 100%; after deductible	30%; after deductible
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Infusion Therapy Administered in the home or physician's office	Covered 100%; after deductible	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Covered 100%; after deductible	30%; after deductible
Transplants	$500 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	30% per admission; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered

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Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Plus Open Formulary	
Preferred Generic Drugs		
Retail	$10 copay	$10 copay
Mail Order	$25 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	$30 copay
Mail Order	$75 copay	Not Applicable
Non-Preferred Generic and Brand-Name Drugs		
Retail	$50 copay	$50 copay
Mail Order	$125 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 31 day supply from Aetna National Network	
Mail Order	A 32-90 day supply from Aetna Rx Home Delivery®.	
Value Plus Specialty	Up to a 30 day supply First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral chemotherapy drugs covered 100%
Value Plus Pre-certification included
Value Plus Step Therapy included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
One transition fill allowed within 90 days of member's effective date
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

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When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

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• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.

PLAN DESIGN & BENEFITS
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• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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