RESOLUTION NO. 16 - 2395

A RESOLUTION OF THE TOWN COMMISSION FOR THE TOWN OF SURFSIDE, FLORIDA, APPROVING GROUP HEALTH AND VISION COVERAGE WITH UNITEDHEALTHCARE, DENTAL COVERAGE WITH GUARDIAN AND TERM LIFE INSURANCE, ACCIDENTAL DEATH, SHORT TERM DISABILITY, AND LONG TERM DISABILITY WITH MUTUAL OF OMAHA; PROVIDING FOR APPROVAL AND AUTHORIZATION; PROVIDING FOR AN EFFECTIVE DATE.

WHEREAS, Adams Benefit is the Town of Surfside ("Town") insurance broker of record and has analyzed the best proposals from competitive health care and other benefit providers for the Town employees; and

WHEREAS, based on the analysis provided by Adams Benefit, the Town has determined that renewing group health and vision coverage with UnitedHealthcare, dental coverage with Guardian and term life insurance, accidental death, short term disability, and long term disability with Mutual of Omaha for qualified Town employees for Fiscal Year 2016/2017 is in the best interest of the Town (See Attachment "A").

NOW THEREFORE, BE IT RESOLVED BY THE TOWN COMMISSION OF THE TOWN OF SURFSIDE, FLORIDA, AS FOLLOWS:

Section 1. Recitals. The above and foregoing recitals are true and correct and are incorporated herein by reference.

Section 2. Approval and Authorization. The Town Commission hereby approves and authorizes the Town Manager and/or designee to enter into an agreement for group health and vision coverage with UnitedHealthcare, dental coverage with Guardian and term life insurance, accidental death, short term disability, and long term disability with Mutual of Omaha for qualified Town employees for Fiscal Year 2016/2017 (See Attachment "A").

Section 3. Effective Date. This Resolution shall become effective immediately upon its adoption.

PASSED AND ADOPTED this 13th day of September 2016.

Motion by Commissioner Karukin,

Second by Mayor Dietch.

FINAL VOTE ON ADOPTION

Commissioner Daniel Gielchinsky	yes
Commissioner Michael Karukin	yes
Commissioner Tina Paul	yes
Vice Mayor Barry Cohen	yes
Mayor Daniel Dietch	yes

Daniel Dietch, Mayor

ATTEST:

Sandra Novoa, MMC, Town Clerk

APPROVED AS TO FORM AND
LEGAL SUFFICIENCY FOR THE TOWN OF SURFSIDE ONLY:

Linda Miller, Town Attorney

ATTACHMENT A

Town of Surfside

Benefit & Premium Illustration - United Health Care

	United Health Care	
	Current - 0H9	Renewal - AHNT Rx 121
	In-Network	In-Network
Calendar Year Deductible (CYD)	$1,000 Ind. $2,000 Family	$1,000 Ind. $2,000 Family
Co-Insurance	100%	100%
Physicians Office	$20 co-pay	$20 co-pay
Specialist Office	$40 co-pay	$40 co-pay
Inpatient Hospital	0% after deductible	0% after deductible
Out-Patient Surgery	0% after deductible	0% after deductible
Out-Patient Major Diagnostic *(e.g., MRI, MRA, PET, CT)*	0% after deductible	0% after deductible
Emergency Room	$350 co-pay	$350 co-pay
Urgent Care Center	$100 co-pay	$100 co-pay
Prescription Drugs	$10/$35/$60/$100	$10/$35/$60/$100
Out of Pocket	$3,000 Ind. $6,000 Family	$3,000 Ind. $6,000 Family
Provider Search	www.myuhc.com	

		Current	Renewal
Employee	11	$ 550.75	$ 603.74
Employee + Spouse	5	$ 1,178.61	$ 1,292.01
Employee + Child(ren)	2	$ 1,123.52	$ 1,231.62
Employee + Family	7	$ 1,685.29	$ 1,847.44
	25	$ 25,995.37	$ 28,496.51

	Current	Renewal
Total Monthly	85 $ 71,351.99	$ 77,028.54

	United Health Care			
	Current - 5Q3		Renewal, AHM8, Rx 121	
	In-Network	Out-Network	In-Network	Out-Network
Calendar Year Deductible (CYD)	$2,000 Ind. $4,000 Family	$5,000 Ind. $10,000 Family	***$1,500 Ind. $3,000 Family***	$5,000 Ind. $10,000 Family
Co-Insurance	90%	50%	90%	50%
Physicians Office	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Specialist Office	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Inpatient Hospital	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Out-Patient Surgery	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Out-Patient Major Diagnostic *(e.g., MRI, MRA, PET, CT)*	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Emergency Room	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Urgent Care Center	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Prescription Drugs	CYD; $10/$35/$60/$100		CYD; $10/$35/$60/$100	
Out of Pocket	$4,000 Ind. $8,000 Family	$10,000 Ind. $20,000 Family	***$4,000 Ind. $6,000 Family***	$10,000 Ind. $20,000 Family
Provider Search	www.myuhc.com			

	Current		Renewal	
28	$	416.65	$	445.82
13	$	891.64	$	954.06
5	$	849.96	$	909.47
14	$	1,274.95	$	1,364.21
60	$	45,356.62	$	48,532.03

This is a brief summary of the benefits and rates offered. The Certificate of Coverage is the governing document for all benefits, requirements and limitations. If there is a variation between this summary and the Certificate of Coverage, the Certificate will govern.

Adams BENEFIT

Town of Surfside

Ancillary Coverage

DENTAL	Guardian DHMO	
Calendar Year Deductible		
Co-Insurance Type 1 - Preventative Type 2 - Basic Type 3 - Major Type 4 - Orthodontia	Scheduled Co-Pays	
	Current	**Renewal**
Employee	$ 14.14	$ 14.14
Employee + Spouse	$ 28.30	$ 28.30
Employee + Child(ren)	$ 36.75	$ 36.75
Employee + Family	$ 52.06	$ 52.06

DENTAL	Guardian PPO	
	In-Network	**Out-Network**
Calendar Year Deductible	$50 Ind. $150 Family	$50 Ind. $150 Family
Co-Insurance		
Type 1 - Preventative	100%	100%
Type 2 - Basic	90%	80%
Type 3 - Major	60%	50%
Type 4 - Orthodontia	50%	50%
Calendar Year Maximum	$2,000 + Max Rollover	
Lifetime Maximum Ortho	$1,500	
Out of Network Reimbursement	UCR	
Waiting Period	None for timely applicants	
	Current	**Renewal**
Employee	$ 41.78	$ 41.78
Employee + Spouse	$ 92.75	$ 92.75
Employee + Child(ren)	$ 114.45	$ 114.45
Employee + Family	$ 160.66	$ 160.66

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Final premium rates may change from those quoted based upon actual enrollment as of the effective date.

Adams BENEFIT

Town of Surfside

Ancillary Coverage

Basic Life & AD&D	Mutual of Omaha		
	Current	Renewal	Alternate
All Active			
Life per $1,000	$0.21	$0.21	$0.22
AD&D per $1,000	$0.03	$0.03	$0.03
	Benefits will reduce to: *65% at age 65* *50% at age 70*		*Benefits will reduce to:* *50% at age 70*
Retirees			
Life per $1,000	$1.25	$1.25	
Grandfathered Retirees			
Life per $1,000	$0.21	$0.21	

Voluntary Life	Mutual of Omaha	
	Current	Renewal
Life per $1,000	$0.39	$0.39
AD&D per $1,000	$0.03	$0.03

Short Term Disability	Mutual of Omaha	
	Current	Renewal
STD per $10 of weekly benefit	$0.30	$0.30

Long Term Disability	Mutual of Omaha	
	Current	Renewal
LTD per $100 of covered monthly payroll	$0.38	$0.38

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Adams BENEFIT

Town of Surfside

Ancillary Coverage

Vision	United Health Care	
Co-Pays		
Exam	$10	
Materials	$25	
Frame Allowance	$130 retail frame allowance; 30% discount on amount over	
Frequency		
Exam	12 Months	
Lenses	12 Months	
Frames	24 Months	
	Current	Renewal
Employee	$ 7.23	$ 7.23
Employee + Spouse	$ 13.34	$ 13.34
Employee + Child(ren)	$ 13.97	$ 13.97
Employee + Family	$ 20.92	$ 20.92

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Adams BENEFIT

UnitedHealthcare®

Benefit Summary

Florida - Choice Plus
HSA - Plan AHM8

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 with an HSA?

Get network freedom and an HSA.

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. You can save money when you use the health savings account (HSA) and 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.**

> **You can open a health savings account (HSA).** An HSA is a personal bank account to help you save and pay for your health care, and help you save on taxes.

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

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.

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-insurance (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
10%	$1,500	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 - Combined Medical and Pharmacy		
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.		
> No one in the family is eligible for benefits until the family coverage deductible is met.		
Medical Deductible - Single Coverage	$1,500 per year	$5,000 per year
Medical Deductible - Family Coverage	$3,000 per year	$10,000 per year
Out-of-Pocket Limit - Combined Medical and Pharmacy		
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.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
> If more than one person in a family is covered under the Policy, the single coverage out-of-pocket limit does not apply.		
Out-of-Pocket Limit - Single Coverage	$4,000 per year	$10,000 per year
Out-of-Pocket Limit - Family Coverage	$6,000 per year	$20,000 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.	50% 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.	50% 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.	50% 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.	50% 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.	50% 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.	10% co-insurance, after the medical deductible has been met.	50% 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		
	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the network medical deductible has been met.
		Notification is required if confined in an Out-of-Network Hospital.
Enteral Formulas		
	10% co-insurance, after the medical deductible has been met.	50% 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.	10% co-insurance, after the medical deductible has been met.	50% 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.	50% 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.	50% 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.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	10% co-insurance, after the medical deductible has been met.	50% 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.	50% 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.	50% co-insurance, after the medical deductible has been met.
Outpatient:	10% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.	50% 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.	50% co-insurance, after the medical deductible has been met.
Outpatient:	10% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.	50% 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
Osteoporosis Treatment		
	10% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.	50% 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.	50% 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.	50% 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.	50% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	10% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	10% co-insurance, after the medical deductible has been met.	50% 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.
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.	50% 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.	50% 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.	10% co-insurance, after the medical deductible has been met.	50% 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.	50% 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.	50% 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:	10% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	10% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.	50% 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.	50% 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.	50% 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		
	10% co-insurance, after the medical deductible has been met.	50% 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
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.	10% co-insurance, after the medical deductible has been met.	50% 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, sexual dysfunction, communication disorders, motor 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 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. 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 as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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

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.

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 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 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 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.

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 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.

Services your plan does not cover (Exclusions)

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, 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.

UnitedHealthcare®

Benefit Summary

Florida - Choice
Consumer - Plan AHNT

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)
$20	$1,000	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	$1,000 per year
Medical Deductible - Family	$2,000 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 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	
	$350 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	
	You pay nothing, after the medical deductible has been met.
Mental Health Services	
Inpatient:	You pay nothing, after the medical deductible has been met.
Outpatient:	$40 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:	$40 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.
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: $20 co-pay per visit. A deductible does not apply.
Specialist Physician Office Visit	$40 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.	$20 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.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Substance Use Disorder Services	
Inpatient:	You pay nothing, after the medical deductible has been met.
Outpatient:	$40 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.
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	
	$100 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.	$20 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, sexual dysfunction, communication disorders, motor 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 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. 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 as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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

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 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 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 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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UNITED *of* OMAHA LIFE INSURANCE COMPANY

GROUP TERM LIFE AND AD&D INSURANCE SUMMARY OF COVERAGE

Town of Surfside
GLUG-369G
Revised: September 1, 2016
All eligible active employees

This Summary of Coverage provides a brief description of some of the terms, conditions, exclusions and limitations of Your employer's Policy. Definitions of capitalized terms in this Summary of Coverage can be found in the Certificate. For a complete description of the terms, conditions, exclusions and limitations of Your employer's Policy, refer to the appropriate section of the Certificate. In the event of a discrepancy between this Summary of Coverage and the Certificate, the Certificate will control. For a copy of the Certificate, contact the group Policyholder or Benefits or Plan Administrator.

This Summary of Coverage is not a contract. You are not necessarily entitled to insurance under the Policy because You received this Summary of Coverage. You are only entitled to insurance if You are eligible in accordance with the terms of the Certificate.

BENEFITS	
Life Insurance Benefit for You	An Amount of Life Insurance equal to Your Annual Salary up to $175,000. In no event will the Amount of Life Insurance be less than $1,000. Any Amount of Life Insurance not a multiple of $1,000 will be changed to the next higher multiple of $1,000. Annual Salary means Your gross Annual Salary received from the Policyholder and in effect immediately prior to the date of loss, as determined by the Policyholder. It includes employee contributions to deferred compensation plans. It does not include commissions, bonuses, overtime pay, shift differential, other extra compensation, or Policyholder contributions to Deferred Compensation plans received from the Policyholder. Note: In the event of death, the benefit paid will equal the benefit amount after any age reductions less any living benefits previously paid under the Policy.
Reductions	Your Life Insurance Benefits will reduce to: • 50% at age 70 If You are age 70 or older on the day You become insured under the Policy, the reduction will be made in accord with Your attained age. Life Insurance Benefits end on the date of Your retirement.

Accidental Death and Dismemberment Benefit for You	A Principal Sum equal to the amount of Your Life Insurance Benefit. If Your Life Insurance Benefit has been reduced by the Living Benefits Option, such reduction will not apply to this Accidental Death and Dismemberment Principal Sum.
EMPLOYEE ELIGIBILITY	
Minimum Work Hours Required	32 hours per week
Eligibility Waiting Period	30 days
Confinement Rule	If an eligible Employee is confined due to an Injury or Sickness or not available for work because of an Injury or Sickness, insurance will begin on the first day of the Policy month which coincides with or follows the day the Employee returns to Active Employment.
When Insurance Begins	An Employee will become insured on the first day of the Policy month which coincides with or follows the day the Employee becomes eligible, provided the Employee is Actively Working on that day.
When Your Classification or the Amount of Insurance Changes	Any change in Your classification, coverage or amount of Your insurance will take effect on the day of the change, provided You are Actively Working on that day. If You are not Actively Working on the day of the change, the following conditions will apply: • If the change involves an increase in the amount of insurance, the change will not take effect until the day You return to Active Work. • If the change involves a decrease in the amount of insurance, the change will take effect on the day of the change.
When Your Insurance Ends	Your insurance will end at midnight at the main office of the Policyholder on the earliest of: • the day the Policy terminates; • the day any premium contribution for Your insurance is due and unpaid; • the day before You enter the Armed Forces on active duty (except for temporary active duty of two weeks or less); or • the last day of the Policy month in which You are no longer eligible. You will no longer be eligible when the earliest of the following occurs: • You are not in an eligible classification described in the Schedule; • Your employment with the Policyholder ends; • You are not Actively Employed; or • You do not satisfy any other eligibility condition described in the Policy.
FEATURES	
Living Benefits Option For You	50% of the amount of the Life Insurance Benefit is available to You if You incur a Terminal Condition, but not to exceed $100,000. Terminal Condition means an Injury or Sickness expected to result in Your death within 12 months and from which there is no reasonable prospect of recovery as determined by Us.
Continuation Due to Layoff or Leave of Absence	Your insurance will continue subject to payment of premium until the last day of the Policy month in which You have been laid off or go on a leave of absence approved by the Policyholder.
Waiver of Premium	If You are determined to be Totally Disabled, Your Life Insurance Benefit will continue without payment of premium until age 65 provided the disability began prior to age 60 and You have met a disability elimination period of 9 consecutive months.

Conversion	If Your employment ends, You may apply for an individual life insurance policy without evidence of good health. You will be responsible for the premium for the coverage.

AD&D BENEFIT SCHEDULE

The AD&D Benefit is paid if an employee is injured as a result of an Accident, and that Injury is independent of Sickness and all other causes. Benefits are paid as indicated below:

Loss	**Benefit**
• Life • Both Hands • Both Feet • Entire Sight of Both Eyes • One Hand and One Foot • One Hand and Entire Sight of One Eye • One Foot and Entire Sight of One Eye • Speech and Hearing (both ears)	Principal Sum
• Entire Sight of One Eye • Speech or Hearing (both ears) • One Hand or One Foot	One-half Principal Sum
• Loss of Thumb and Index Finger of Same Hand	One-fourth Principal Sum
Paralysis	**Benefit**
• Quadriplegia (total Paralysis of both upper and lower limbs)	Principal Sum
• Triplegia (total Paralysis of three limbs)	Three-quarters Principal Sum
• Paraplegia (total Paralysis of both lower limbs) • Hemiplegia (total Paralysis of an upper and a lower limb)	One-half Principal Sum
• Uniplegia (total Paralysis of a limb)	One-fourth Principal Sum
Other Benefits	**Benefit**
Airbag Benefit	10% of the Principal Sum, up to $50,000.
Child Education Benefits	5% of the Principal Sum, up to $5,000.
Common Carrier Benefits	An amount equal to the Principal Sum. In no event will this benefit exceed $1,000,000.
Seat Belt Benefits	10% of the Principal Sum, up to $50,000.

AD&D EXCLUSIONS

We will not pay for any loss which:

- results, whether the Insured Person is sane or insane, from:
  - an intentionally self-inflicted Injury or Sickness; or
  - suicide or attempted suicide;
- results from the Insured Person's participation in a riot or in the commission of a felony;
- results from an act of declared or undeclared war or armed aggression;
- is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
- is not permanent, unless specifically provided;
- occurs more than 365 days after the Injury. NOTE: This 365 day limit will not apply if You are in a coma or being kept alive by an artificial support system at the end of the 365 days;
- does not result from an Accident;
- is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
- results from Injuries You receive in any aircraft while operating, riding as a passenger, boarding or leaving. This exception does not apply while You are riding as a passenger in a commercial aircraft on a regularly scheduled flight or while Traveling on Business of the Policyholder;
- results in Injuries You receive while riding in any aircraft engaged in:
  - racing;
  - endurance tests; or
  - acrobatic or stunt flying;
- is caused by You, and is a result of Injuries You receive, while under the influence of any Controlled Drug, unless administered on the advice of a Physician; or
- is caused by You, and is a result of Injuries You receive, while Intoxicated.

Publication Date: September 6, 2016

UnitedHealthcare®
A UnitedHealth Group Company

UnitedHealthcare Vision Benefit Summary Plan 4

Benefits at a **Network Provider**

When you visit a network provider and receive these covered services....

Vision Exam	You will pay a $10 copay at the time of service.
Materials	You will pay a $25 copay at the time of service. The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contact lenses in lieu of eyeglasses.
Pair of Lenses (for spectacles) • Standard single vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular	Options, such as progressive lenses, polycarbonate lenses, tints, UV, and anti-reflective coating, may be available at a discount. Standard scratch-resistant coating is covered-in-full.
Frames	
• Covered-in-full frame	Other than copay, all covered-in-full frames are fully covered.
• Frame outside covered-in-full selection	If you select a frame from outside the covered-in-full selection, you will receive a $50 wholesale frame allowance (approximate retail value of $120-$150) at our private practice chain providers; and a $130 retail frame allowance at our retail chain providers.
Contact Lenses*	
• Covered-in-full elective contact lenses	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for the most popular brands on the market. If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UnitedHealthcare Vision's covered-in-full contact lenses may vary by provider.
• All other elective contacts	A $105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of UnitedHealthcare Vision's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.
• Necessary contact lenses**	Covered-in-full (after applicable copay)
Frequencies	Exam - Once every 12 months Lenses - Once every 12 months Frames - Once every 24 months

** Contact lenses are in lieu of spectacle lenses and a frame.*

*** Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implan; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision concerning the reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.*

Benefits at an **Non-Network Provider**

When you visit an non-network provider, you will be reimbursed up to the non-network maximums:

Service	Amount	Service	Amount
Exam	Up to $40	Lenticular Lenses	Up to $80
Single Vision Lenses	Up to $40	Frames	Up to $45
Bifocal Lenses	Up to $60	Elective Contacts	Up to $105
Trifocal Lenses	Up to $80	Necessary Contacts**	Up to $210

Network Provider - Copays and non-covered patient options are paid to provider by program participant.

Non-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare Vision reimburses the customer for services rendered up to the maximum allowance. All receipts must be submitted at the same time. Copays do not apply to non-network benefits.

Important to Remember:

Network

• Always identify yourself as a UnitedHealthcare Vision customer when making your appointment. This will assist your provider in obtaining a claim authorization before your visit.

• Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare Vision selection.

• Your contact lens allowance is applied to the fitting/evaluation fees, as well as the purchase of non-covered contact lenses. For example, if your allowance is $105, and the fitting fee and evaluation is $33, you will have $72 toward the purchase of non-covered contact lenses. Evaluation and fitting fees may vary among providers and type of fitting required.

• Patient options, such as UV coating, progressive lenses, etc., are not covered-in-full, but may be available at a discount.

Non-Network Claims

• Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

Network and Non-Network Benefits

• Benefits are available every 12 or 24 months (depending on the benefit frequency), based on last date of service.

• Benefits for contact lenses are in lieu of spectacle lenses and frames.

Choice and Access of Vision Care Providers

UnitedHealthcare Vision offers its vision program through a national network including both private practice and retail chain providers.

To access the Provider Locator service, visit our Web site at **www.myuhcspecialtybenefits.com** (then select vision) or call **1-800-839-3242**, 24 hours a day, seven days a week.

Retain this UnitedHealthcare Vision Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.

Customer Service is available toll-free at 1-800-638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time, Monday through Friday; and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

** Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implan; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision concerning the reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

The following Services and Materials are excluded from coverage under the Policy: post cataract lenses; non-prescription items; medical or surgical treatment for eye disease, which requires the services of a physician; Worker's Compensation services or materials; services or materials that the patient, withot cost, obtains from any governmental organization or program; services or materials that are not specifically covered by the Policy; replacement or repair of lenses and/or frames that have been lost or broken and cosmetic extras.

GUARDIAN®

Town of Surfside

Dental Benefit Summary

Group Number: 00516368

About Your Benefits:

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400[1]? Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country, who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same community, you will benefit from lower out-of-pocket costs, quality care from screened and reviewed dentist, no claim forms to file, and excellent customer service. Enroll today and smile next time you see your dentist!

[1]http://health.costhelper.com/dental-crown.html.

Option 1: With your **Pre-Paid** plan, you enjoy negotiated discounts from our network dentists. You pay a fixed copay for each covered service. Out-of-network visits are not covered.

Option 2: With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	**Option 1: Pre-Paid**	**Option 2: PPO**	
Your Network is	Managed DentalGuard	DentalGuard Preferred	
Calendar year deductible		*In-Network*	*Out-of-Network*
Individual	No deductible	$50	$50
Family limit		3 per family	
Waived for		Preventive	Preventive
Charges covered for you (co-insurance)	*Network only*	*In-Network*	*Out-of-Network*
Preventive Care	You pay a copay for each	100%	100%
Basic Care	covered procedure. See	90%	80%
Major Care	"Plan Details", for	60%	50%
Orthodontia	more information.	50%	50%
Annual Maximum Benefit	Unlimited	$2000	$2000
Maximum Rollover	Maximum Rollover is not	Yes	
Rollover Threshold	applicable for this plan type.	$800	
Rollover Amount		$400	
Rollover In-network Amount		$600	
Rollover Account Limit		$1500	
Lifetime Orthodontia Maximum	Not Applicable	$1500	
Office visit copay	$0	None	
Dependent Age Limits	26 *	26 *	

***Family coverage** for spouse and children if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.

A Sample of Services Covered by Your Plan:

		Option 1: Pre-Paid	Option 2: PPO	
		You Pay	*Plan pays (on average)*	
		Network only	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	$0	100%	100%
	Frequency:	2 times in 12 months^	2 in 12 Months	
	Fluoride Treatments	$0	100%	100%
	Limits:	No Age Limits	Under Age 19	
	Oral Exams	$0	100%	100%
	Sealants (per tooth)	$0	100%	100%
	X-rays	$0	100%	100%
Basic Care	Anesthesia*	Restrictions Apply	90%	80%
	Fillings‡	$0	90%	80%
	Perio Surgery	$200-380	90%	80%
	Periodontal Maintenance	$0	90%	80%
	Frequency:	2 times in 12 months^ (Standard)	Once Every 6 Months (Standard)	
	Root Canal	$120-270	90%	80%
	Scaling & Root Planing (per quadrant)	$0	90%	80%
	Simple Extractions	$0	90%	80%
	Surgical Extractions	$30-200	90%	80%
Major Care	Bridges and Dentures	$381-575	60%	50%
	Inlays, Onlays, Veneers**	$250-370	60%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	$0-160	60%	50%
	Single Crowns	$375	60%	50%
Orthodontia	Orthodontia	$1,500-2,800	50%	50%
	Limits:	Adults & Child(ren)	Child(ren)	
Cosmetic Care	Bleaching	$165	Not Covered	Not Covered

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings. (^Additional cleanings are available for an additional co-pay).

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00516368

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan and dental network, which can be found on the first page of your dental benefit summary.