



Benefit Summary
ASO Navigate Plus
 REEP Medical Plan Navigate 500

This document is provided as a sample and does not reflect actual benefits. A customized Benefit Summary or Summary Plan Description (SPD) will be created during implementation of the business.

United HealthCare Services, Inc. and REEP want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com**® - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	\$500 per year	\$1,000 per year
Family Deductible	\$1500 per year	\$3,000 per year
<ul style="list-style-type: none"> • Member Copayments do not accumulate towards the Deductible unless otherwise notated within the specific benefit category below. • All individual Deductible Amounts will count toward the family Deductible, but an individual will not have to pay ore than the individual Deductible amount. 		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$3,000 per year	\$6,000 per year
Family Out-of-Pocket Maximum	\$9,000 per year	\$18,000 per year
<ul style="list-style-type: none"> • The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will note have to pay more than the individual Out-of-Pocket Maximum amount. 		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	90% after Deductible has been met.	70% after Deductible has been met.
Prescription Drug Benefits		
<ul style="list-style-type: none"> • Prescription drug benefits are shown under separate cover. 		
Information on Benefit Limits		
<ul style="list-style-type: none"> • The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendaryear basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. • In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services. 		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Acupuncture		
	90% after Deductible has been met	70% after Deductible has been met
Ambulance Services – Emergency and Non-Emergency		
	Emergency: 90% after Deductible has been met. Non-Emergency: 90% after Deductible has been met. <i>Prior Authorization is required for Non-Emergency Ambulance.</i>	Emergency: 90% after Network Deductible has been met. Non-Emergency: 90% after the Deductible has been met. <i>Prior Authorization is required for Non-Emergency Ambulance.</i> <i>Air Ambulance - \$50,000 Limit</i>
Dental Services – Accident Only		
Benefits are limited to \$3,000 maximum per year and \$900 maximum per tooth.	90% after Deductible has been met.	70% after Network Deductible has been met.
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	90% after Deductible has been met.	70% after Deductible has been met. <i>Prior Authorization is required for Durable Medical Equipment that costs more than \$1,000.</i>
Emergency Health Services - Outpatient		
	90% Deductible does not apply	90% Deductible does not apply

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: A single purchase (including repair/replacement) per hearing impaired ear every three years.	90% after Deductible has been met.	70% after Deductible has been met. Pre-service Notification is required
Home Health Care		
Benefits are limited to 100 visits per year	90% after Deductible has been met.	70% after Deductible has been met. <i>Prior Authorization is required for certain services.</i>
Hospice Care		
	100% after Deductible has been met.	80% after Deductible has been met. <i>Prior Authorization is required for Inpatient Stay.</i>
Hospital – Inpatient Stay		
	90% after Deductible per Inpatient Stay (with a referral from your Primary Physician). 70% after Deductible per Inpatient Stay (without a referral from your Primary Physician).	70% after Deductible has been met. <i>Prior Authorization is required.</i>
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90% after Deductible has been met.	70% after Deductible has been met. <i>Prior Authorization is required for sleep studies.</i>
Lab, X-Ray and Major Diagnostics – CT, PET, MRI and Nuclear Medicine - Outpatient		
	90% after Deductible has been met.	70% after Deductible has been met. <i>Prior Authorization is required.</i>
Mental Health Services		
	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Neurobiological Disorders - Autism Spectrum Disorders		
	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	Coverage provided by Express Scripts Customer Service Phone Number: (888) 806-4969	Coverage provided by Express Scripts Customer Service Phone Number: (888) 806-4969

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Physician Fees for Surgical and Medical Services		
	90% after Deductible has been met for services provided by your Primary Physician or Network obstetrician or gynecologist. 90% after Deductible has been met (with a referral from your Primary Physician). 70% after Deductible has been met (without a referral from your Primary Physician).	70% after Deductible has been met.
Physician's Office Services – Sickness and Injury		
Primary Physician or Network obstetrician or gynecologist	100% after you pay a \$30 Copayment per visit. Deductible does not apply	70% after Deductible has been met. <i>Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.</i>
Physician Office Visit (with a referral from your Primary Physician)	100% after you pay a \$30 Copayment per visit.	70% after Deductible has been met. <i>Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.</i>
Physician Office Visit (without a referral from your Primary Physician)	70% after Deductible has been met	70% after Deductible has been met. <i>Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.</i>
> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary. For services provided in the Physician's Office, a \$30 Copayment will apply to the initial office visit only.	<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician or Network obstetrician or gynecologist	100% Deductible does not apply.	Non-Network Benefits are not available.
Physician Office Visit (with a referral from your Primary Physician)	100% Deductible does not apply.	
Physician Office Visit (without a referral from your Primary Physician)	100% Deductible does not apply.	
Lab, X-Ray or other preventive tests		
Primary Physician or Network obstetrician or gynecologist	100% Deductible does not apply.	Non-Network Benefits are not available.
Physician Office Visit (with a referral from your Primary Physician)	100% Deductible does not apply.	
Physician Office Visit (without a referral from your Primary Physician)	100% Deductible does not apply.	
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	90% after Deductible has been met.	70% after Deductible has been met <i>Prior Authorization is required for Prosthetic Devices that costs more than \$1,000.</i>
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	<i>Prior Authorization is required for certain services.</i>

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 24 visits of physical therapy 24 visits of occupational therapy 24 visits of manipulative treatment 24 visits of speech therapy Unlimited visits of pulmonary rehabilitation Unlimited visits of cardiac rehabilitation Unlimited visits of post-cochlear implant aural therapy Unlimited visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	90% after Deductible has been met. (for all other rehabilitation services). 90% after Deductible has been met, per visit for Manipulative Treatment and vision therapy (provided with a referral from your Primary Physician). 70% after Deductible has been met, per visit for Manipulative Treatment and vision therapy (provided without a referral from your Primary Physician).	70% after Deductible has been met.
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	90% after Deductible has been met for services provided by your Primary Physician or Network obstetrician or gynecologist. 90% after Deductible has been met (with a referral from your Primary Physician). 70% after Deductible has been met (without a referral from your Primary Physician).	70% after Deductible has been met. <i>Prior Authorization is required for certain services.</i>
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited to 100 days per year	90% after Deductible has been met per Inpatient Stay.	70% after Deductible has been met. <i>Prior Authorization is required.</i>
Substance Use Disorder Services		
	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Surgery – Outpatient		
Lab and X-ray services through Outpatient Hospital is limited to a \$350 maximum per admission	90% after Deductible has been met for services provided by your Primary Physician or Network obstetrician or gynecologist. 90% after Deductible has been met (with a referral from your Primary Physician). 70% after Deductible has been met (without a referral from your Primary Physician).	70% after Deductible has been met. <i>Prior Authorization is required for certain services.</i>
Transplantation Services		
For Network Benefits, services must be received at a Designated Facility.	90% after Deductible has been met per Inpatient Stay. <i>Prior Authorization is required.</i>	Non-Network Benefits are not available.
Urgent Care Center Services		
	100% after you pay a \$30 Copayment per visit.	70% after Deductible has been met.
> In addition to the Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: Lab, X-Ray; CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
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.	100% after you pay a \$30 Copayment per visit. Deductible does not apply.	Non-Network Benefits are not available.

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Vision Examinations		
Benefits are limited as follows: 1 exam every 2 years	100% after you pay a \$30 Copayment per visit.	Non-Network Benefits are not available.

MEDICAL EXCLUSIONS

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

Alternative Treatments
Acupressure; aromatherapy; hypnosis; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

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 dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extractions (including wisdom teeth), restoration and replacement of teeth, medical or surgical treatments of dental conditions, services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

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 as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

Coverage provided by Express Scripts
Customer Service Phone Number: (888) 806-4969

Experimental or Investigational or Unproven Services
Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

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 the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

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

Medical Supplies and Equipment
Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health, Neurobiological/Autism Spectrum, and Substance-Related and Addictive Disorders

Coverage provided by MHN
Customer Service Phone Number: (888) 327-0020

Nutrition
Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

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 and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot and cold compresses; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance
Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemoablation and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss, except for temporary loss of hair resulting from treatment of a malignancy.

Procedures and Treatments
Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers
Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction
Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan
Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If

MEDICAL EXCLUSIONS

coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Inlacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy. 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 of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactive disorder; TBI; or dyslexia.

United HealthCare Services, Inc. does not treat members differently because of sex, age, race, color, disability or national origin.

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

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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