

# UnitedHealthcare

## iPlan HSA Choice Plus *Plan HDF*

With this iPlan HSA Choice Plus high-deductible health plan coverage, you have the option to open a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service. The account acts like a regular checking account with a debit card and accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable among employers. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

**Under the iPlan HSA Choice Plus high-deductible medical plan, your annual deductible and out of pocket maximum includes both medical expenses and pharmacy expenses. All expenses are your responsibility until the deductible is reached.** iPlan HSA Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

### ***Some of the Important Benefits of Your Plan:***

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination<sup>SM</sup> services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Notice: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all the rules very carefully and compare them with the rules of any other plan that covers you and your family.

# iPlan HSA Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. <b>More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.</b></p> <p>If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.</p> <p>Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.</p> <p>Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.</p> <p>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.</p> <p>*Prior Notification is required for certain services.</p>	<p><b>Combined Medical and Drug Annual Deductible:</b> For single coverage, the Annual Deductible is \$2,850 per Covered Person per calendar year. For family coverage, the Annual Deductible is \$5,600 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied.</p> <p><b>Combined Medical and Drug Out-of-Pocket Maximum:</b> For single coverage, the Out-of-Pocket Maximum is \$2,850 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is \$5,600 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.</p> <p><b>Maximum Policy Benefit:</b> \$5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.</p>	<p><b>Combined Medical and Drug Annual Deductible:</b> For single coverage, the Annual Deductible is \$5,000 per Covered Person per calendar year. For family coverage, the Annual Deductible is \$10,000 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied.</p> <p><b>Combined Medical and Drug Out-of-Pocket Maximum:</b> For single coverage, the Out-of-Pocket Maximum is \$10,000 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is \$20,000 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.</p> <p><b>Maximum Policy Benefit:</b> \$5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.</p>
<b>1. Ambulance Services - Emergency only</b>	Ground Transportation: 0% of Eligible Expenses Air Transportation: 0% of Eligible Expenses	Same as Network Benefit
<b>2. Dental Services - Accident only</b>	*0% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
<b>3. Durable Medical Equipment</b> Network and Non-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.	0% of Eligible Expenses	*20% of Eligible Expenses *Prior notification is required when the cost is more than \$1,000.
<b>4. Emergency Health Services</b>	0% of Eligible Expenses	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
<b>5. Eye Examinations</b> Refractive eye examinations are limited to one every other calendar year from a Network Provider.	0% of Eligible Expenses	20% of Eligible Expenses Eye Examinations for refractive errors are not covered.
<b>6. Home Health Care</b> Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	0% of Eligible Expenses	*20% of Eligible Expenses
<b>7. Hospice Care</b> Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	0% of Eligible Expenses	*20% of Eligible Expenses
<b>8. Hospital - Inpatient Stay</b>	0% of Eligible Expenses	*20% of Eligible Expenses
<b>9. Injections Received in a Physician's Office</b>	0% of Eligible Expenses	20% per injection

# YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<b>10. Maternity Services</b>	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
<b>11. Outpatient Surgery, Diagnostic and Therapeutic Services</b>		
Outpatient Surgery	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic Services	For preventive diagnostic services: No Copayment	20% of Eligible Expenses
	For preventive mammography testing: No Copayment	20% of Eligible Expenses
	For sickness and injury related diagnostic services: 0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Therapeutic Treatments	0% of Eligible Expenses	20% of Eligible Expenses
<b>12. Physician's Office Services</b>	Preventive medical care: No Copayment	20% of Eligible Expenses
Network and Non-Network Benefits for Child Health Supervision Services are limited to \$500 from birth to age 1, thereafter; \$150 per calendar year from ages 1 to 9.	Sickness & Injury: 0% of Eligible Expenses	
<b>13. Professional Fees for Surgical and Medical Services</b>	0% of Eligible Expenses	20% of Eligible Expenses
<b>14. Prosthetic Devices</b>	0% of Eligible Expenses	20% of Eligible Expenses
Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.		
<b>15. Reconstructive Procedures</b>	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
<b>16. Rehabilitation Services - Outpatient Therapy</b>	0% of Eligible Expenses	20% of Eligible Expenses
Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.		
<b>17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b>	0% of Eligible Expenses	*20% of Eligible Expenses
Network and Non-Network Benefits are limited to 60 days per calendar year.		
<b>18. Transplantation Services</b>	*0% of Eligible Expenses	*20% of Eligible Expenses Benefits are limited to \$30,000 per transplant.
<b>19. Urgent Care Center Services</b>	0% of Eligible Expenses	20% of Eligible Expenses

## Additional Benefits

<b>Cytologic Screening and Screening Mammography</b> Benefits for Screening Mammography performed in Ohio are limited to \$85 per test.	Same as 11, 12 and 13	Same as 11, 12 and 13
<b>Mental Health Services</b> For Network Benefits, you must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year for outpatient Mental Health Services, and to 20 days per calendar year for inpatient Mental Health Services.	For outpatient Mental Health Services: 0% of Eligible Expenses  For inpatient Mental Health Services: 0% of Eligible Expenses	20% of Eligible Expenses
<b>Spinal Treatment</b> Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	0% of Eligible Expenses	20% of Eligible Expenses
<b>Substance Abuse Services - Outpatient, Inpatient, and Intermediate</b> For Network Benefits, you must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year for outpatient Substance Abuse Services, and 20 days per calendar year for inpatient Substance Abuse Services.	For outpatient Substance Abuse Services: 0% of Eligible Expenses  For inpatient and intermediate Substance Abuse Services: 0% of Eligible Expenses	20% of Eligible Expenses

## Exclusions

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

### A. Alternative Treatments

Acupressure; hypnosis; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

### B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

### C. Dental

Except as specifically described as covered in Section 1 of the COC for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

### D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

### E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, 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, Investigational or Unproven in the treatment of that particular condition.

Refer to Section 6 of the COC (External Independent Review for Terminal Conditions) for exceptions to this exclusion.

### F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

### G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except

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when used with Durable Medical Equipment as described in Section 1 of the COC.

### H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of Mental Illnesses which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as determined by the Mental Health/Substance Abuse Designee, including, but not limited to, conduct and impulse control disorders; personality disorder; and paraphilias.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements. Residential treatment services.

### I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

### J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

### K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

### L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

### M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, or similar legislation. If coverage under

workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness 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 and health services while on active military duty.

This exclusion does not apply if you have continued coverage during a call to military duty as described in Section 8 of the COC under the heading Continuation of Coverage During Military Service.

#### **N. Transplants**

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

#### **O. 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 transplantation services may be reimbursed at our discretion. Emergency ambulance transportation is a Covered Health Service as described in Section 1 of the COC.

#### **P. Vision and Hearing**

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

#### **Q. Other Exclusions**

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising before the date your coverage under the Policy ends. This exclusion does not apply when coverage is extended as described in Section 8 of the COC under the heading of Extended Coverage if You are an Inpatient.

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 that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer, or as necessary to safeguard a Covered Person's health due to a non-dental physiological impairment. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

#### **R. Preexisting Conditions**

Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following: the date you have had Continuous Creditable Coverage for 12 months; or the date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee. This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

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This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.