UnitedHealthcare
HRA Choice Plus *Plan ZCO*

A good way to think about the HRA is that your employer provides you with a pool of money to use toward medical expenses. We call this your Health Reimbursement Account (HRA). Your employer determines the HRA amount. You decide how to spend it. You can use your HRA for any covered expense, including deductibles. To help you with healthcare spending decision-making, we offer tools on myuhc.com, including a treatment cost estimator, healthcare resources that provide you with information about medical services, and your Health Reimbursement Account balance.

HRA 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:

Visit any physician within our vast nationwide network for cost savings and freedom from the hassle of paperwork.

See any specialist in our network without a referral.

Visit the hospital that best suits your needs from thousands of participating facilities nationwide.

Emergencies are covered anywhere in the world.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery, when covered health services are provided.

Prenatal care is included.

Routine check-ups are included.

Childhood immunizations are provided.

Mammograms are included.

Pap smears are included.

Vision and hearing screenings are covered.

Care Coordination[SM] services are available to help identify and prevent delays in care for those who might need specialized help

Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
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. **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.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. 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. Network health care services under this benefit plan are covered only when provided, arranged, or authorized by a Network Physician.	**Network Annual Deductible:** $1,200 per Covered Person per Policy year, not to exceed $2,400 for all Covered Persons in a family. **Network Annual Out-of-Pocket Maximum:** $1,200 per Covered Person, per Policy year, not to exceed $2,400 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. **Network Maximum Policy Benefit:** No Maximum Policy Benefit	**Non-Network Annual Deductible:** $1,300 per Covered Person per Policy year, not to exceed $2,600 for all Covered Persons in a family. **Non-Network Annual Out-of-Pocket Maximum:** $3,500 per Covered Person, per Policy year, not to exceed $5,200 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. **Non-Network Maximum Policy Benefit:** $5,000,000 per Covered Person
1. Care in medical offices for treatment of Illness or Injury Refractive eye examinations are limited to one every other Policy year from a Network Provider.	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
2. Well-Child Visits	No Copayment. Deductible does not apply.	20% of Eligible Expenses, after Deductible.
3. Inpatient Hospital Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
4. Outpatient Hospital Service	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
5. Mental Health and Substance Abuse Services-Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee for Network and Non-Network Benefits. Network and Non-Network benefits are limited to 60 days per Policy year.	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
6. Mental Health and Substance Abuse-- Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee for Network and Non-Network Benefits.	30% of Eligible Expenses, after Deductible	50% of Eligible Expenses, after Deductible.
7. Emergency Services	$100 per visit. (waived if Emergency visit results in a Hospital admission), after Deductible.	Same as Network Benefit
8. Detoxification	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
9. Ambulance Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
10. Preventative Services	No Copayment and/or Coinsurance. Deductible does not apply.	20% of Eligible Expenses, after Deductible.
11. Prostate Cancer Screening/Colorectal Cancer	No Copayment and/or Coinsurance. Deductible does not apply.	20% of Eligible Expenses, after Deductible.
12. Mammography Services	No Copayment and/or Coinsurance. Deductible does not apply.	20% of Eligible Expenses, after Deductible.
13. Home Health Care Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
14. Hospice Care Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
15. Durable Medical Equipment	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
16. Outpatient Laboratory and Diagnostic Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
17. Bone Mass Measurement	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
18. Rehabilitation Services - Outpatient Therapy Network and Non-Network Benefits are limited as follows: 30 visits of physical therapy; 30 visits of occupational therapy; and 30 visits of speech therapy per Policy year.	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
19. Chiropractic Services Benefits are limited to 20 visits per Policy year.	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
20. Skilled Nursing Facility Benefits are limited to 100 days per Policy year.	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.

YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
21. Infertility Services	50% of Eligible Expenses, after Deductible.	50% of Eligible Expenses, after Deductible.
22. Nutritional Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
23. Transplantation Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
24. Medical Foods	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
25. Family Planning Services Including: Prescription contraceptive drugs or devices and voluntary sterilization.	No Copayment and/or Coinsurance, after Deductible.	For service other than prescription drugs and contraceptive devices, 20% of Eligible Expenses, after Deductible.
26. Habilitative Services 0-19 years old	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
27. Blood Products	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
28. Pregnancy and Maternity Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
29. Prescription Drugs. Prescription drugs include insulin and birth control drugs.	Refer to your Pharmacy Benefit Summary.	Same as Network
30. Controlled Clinical Trials	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
31. Services Approved by a Carrier's Case Management Program	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
32. Diabetes Treatment, Equipment and Supplies	Same as Durable Medical Equipment and prescription drugs, whichever applies.	Same as Durable Medical Equipment and prescription drugs, whichever applies.
33. Reconstructive Breast Surgery and Breast Prosthesis	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
34. Audiology Screening for Newborns	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
35. Dental Anesthesia and Hospital Services	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
36. Chlamydia Screening	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
37. Hearing Aids Benefits are limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months for ages 0-18 years.	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
38. Surgical treatment of Morbid Obesity	No Copayment and/or Coinsurance, after Deductible.	20% of Eligible Expenses, after Deductible.
Ostomy Supplies Benefits for ostomy supplies including only the following: Pouches, face plates, belts, irrigation sleeves, bags, catheters and skin barriers.	No Copayment and/or Coinsurance. Deductible does not apply.	20% of Eligible Expenses, after Deductible.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: Covered Health Services) or through a Rider to the Certificate.

Services that are not medically necessary.

Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.

Services that are beyond the scope of practice of the Health Care Practitioner performing the service.

Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for Services received for which the recipient is liable.

Services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.

The purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury.

Personal Care services and Domiciliary services.

Services rendered by a Health Care Practitioner who is the Covered Person’s spouse, mother, father, daughter, son, brother or sister.

Experimental Services.

Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transplant, or cryogenic or other preservation techniques used in these or similar procedures.

Services to reverse a voluntary sterilization procedure.

Services for sterilization or reverse sterilization for a Dependent minor.

Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services.

Services incurred before the effective date of Coverage for a Covered Person.

Services incurred after a Covered Person's termination of Coverage, including any extension of benefits.

Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

Services for injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a worker's compensation law.

Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

Personal hygiene and convenience items including, but not limited to air conditioners, humidifiers, or physical fitness equipment.

Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.

Inpatient admissions primarily for diagnostic studies, unless authorized by the Company.

The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers. This exclusion does not include hearing aids for minor children as described above in Section 1.

Except for Covered Ambulance Services, travel, whether or not recommended by a Health Care Practitioner.

Except for Emergency Services, services received while the Covered Person is outside the United States.

Immunizations related to foreign travel.

Unless otherwise specified in Section 1, dental work or treatment which includes Hospital or professional care in connection with:

The operation or treatment for the fitting or wearing of dentures; Orthodontic care of malocclusions; and Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident and the treatment is received within 6 months of the accident.

Dental implants.

Accidents occurring while and as a result of chewing.

Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these Services are determined to be medically necessary.

Arch support, orthotic devices, in -shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be medically necessary.

Inpatient admissions primarily for physical therapy, unless authorized by us.

Treatment leading to or in connection with transsexualism, or sex changes or modification, including but not limited to surgery.

Treatment of sexual dysfunction not related to organic disease.

Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.

Organ transplants except those specifically stated as Covered service.

Nonhuman organs and their implantation.

Nonreplacement fees for blood and blood products.

Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a covered service.

Wigs or cranial prosthesis.

Weekend admission charges, except for emergencies and maternity, unless authorized by us.

Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.

Temporomandibular joint syndrome (TMJ) treatment and treatment for cranionmandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if medically necessary and there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.

Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the Services are payable under a medical expense payment provisions of an automobile insurance Policy.

Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.

Services for, or related to, the removal of an organ from a Covered Person for purposes of transplantation into another person, unless the:

A. Transplant recipient is Covered under the Plan and is undergoing a Covered transplant; and

B. Services are not payable by another carrier.

Physical examinations required for obtaining or continuing employment, insurance, or government licensing,

Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

Private Hospital room, unless authorized by us.

Private duty nursing, unless authorized by us.

Treatment for mental health or substance abuse not authorized by us through our Mental Health/Substance Abuse Designee, or mental health or substance abuse condition determined by us through our Mental Health/Substance Abuse Designee to be untreatable.

Services related to smoking cessation.

UnitedHealthcare

*Pharmacy Management Program **Plan 00Y***

UnitedHealthcare's pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 56,000 nationwide) to provide convenient access to medications.

While most pharmacies participate in our network, you should check first. Call your pharmacist or visit our online pharmacy service at www.myuhc.com. The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

Copayment per Prescription Order or Refill

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment or the mail order Pharmacy's Prescription Drug Cost. Also note that some Prescription Drug Products require that you notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven. In vitro fertilization benefits are not covered.

	Tier 1	Tier 2	Tier 3
Retail Network Pharmacy For up to a 31 day supply	**$10** Copayment per prescription/refill - $25 for up to a 90 day supply of a Maintenance Drug in a singe dispensing).	**$30** Copayment per prescription/refill - $75 for up to a 90 day supply of a Maintenance Drug in a single dispensing).	**$50** Copayment per prescription/refill - $125 for up to a 90 day supply of a Maintenance Drug in a single dispensing).
Retail Non-Network Pharmacy For up to a 31 day supply	**$10** Copayment per prescription/refill - $25 for up to a 90 day supply of a Maintenance Drug in a singe dispensing).	**$30** Copayment per prescription/refill - $75 for up to a 90 day supply of a Maintenance Drug in a single dispensing).	**$50** Copayment per prescription/refill - $125 for up to a 90 day supply of a Maintenance Drug in a single dispensing).

Other Important Cost Sharing Information

*Our Preferred Drug List includes those drugs available to you at the most affordable cost. It is one of the best ways to maximize your prescription drug benefits. The drug list, developed by physicians and pharmacists on our national Pharmacy and Therapeutics committee, includes a wide selection of generic and brand name prescription medications commonly prescribed by physicians. The Preferred Drug List is updated throughout the year. The most current version is available at our online pharmacy at www.myuhc.com.

UnitedHealthcare of the Mid-Atlantic, Inc. and United Health Care Insurance Company

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

	Network and Non-Network Pharmacy
Annual Drug Deductible	**No Annual Drug Deductible**

This summary of Benefits is intended only to highlight your Benefits for outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all your outpatient prescription drug expenses. Please refer to your Outpatient Prescription Drug Rider and 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 Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage prevail. Capitalized terms in the Benefit Summary are defined in the Outpatient Prescription Drug Rider and/or Certificate of Coverage.