UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

Florida - Choice Plus
Consumer - 20/500/80% Plan 8M1 Modified

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **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 much, much 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.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	$500 per year	$1,000 per year
Family Deductible	$1,000 per year	$2,000 per year

> 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 more than the individual Deductible amount.

Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	$2,500 per year	$6,000 per year
Family Out-of-Pocket Maximum	$5,000 per year	$12,000 per year

> All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.

> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

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

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UnitedHealthcare of Florida, Inc.

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Contract or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid. In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services.

> When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $20 Copayment per visit.	60% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a $30 Copayment per visit.	60% after Deductible has been met.
		Prior Authorization is required for Genetic Testing - BRCA.

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100%, Copayments and Deductibles do not apply.	Non-Network Benefits are not available, except for "Child Health Supervision Services," one annual female physical, including a pap smear and a mammogram.
Specialist Physician Office Visit	100%, Copayments and Deductibles do not apply.	
Lab, X-Ray or other preventive tests	100%, Copayments and Deductibles do not apply.	

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Urgent Care Center Services		
	100% after you pay a $75 Copayment per visit.	60% 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: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Types of Coverage	Network Benefits	Non-Network Benefits
Emergency Health Services - Outpatient		
	100% after you pay a $200 Copayment per visit.	100% after you pay a $200 Copayment per visit. *Notification is required if confined in a non-Network Hospital.*
Hospital - Inpatient Stay		
	80% after Deductible has been met.	60% after Deductible has been met. *Prior Authorization is required.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	80% after Deductible has been met.	80% after Network Deductible has been met.
Air Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	80% after Deductible has been met.	80% after Network Deductible has been met.
	Prior Authorization is required for non-Emergency Ambulance.	*Prior Authorization is required for non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	80% after Deductible has been met.	60% after Deductible has been met. *Prior Authorization is required.*
Dental Services - Accident Only		
	80% after Deductible has been met.	80% after Network Deductible has been met.
	Prior Authorization is required.	*Prior Authorization is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	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.	
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for Durable Medical Equipment in excess of $1,000.
Durable Medical Equipment		
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.	80% after Deductible has been met.	60% after Deductible has been met.
		Prior Authorization is required for Durable Medical Equipment in excess of $1,000.
Habilitative Services		
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.	
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are further limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met.	60% after Deductible has been met.

Types of Coverage	Network Benefits	Non-Network Benefits
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met.	60% after Deductible has been met. *Prior Authorization is required.*
Hospice Care		
	80% after Deductible has been met.	60% after Deductible has been met. *Prior Authorization is required for Inpatient Stay.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	100% Deductible does not apply.	60% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	100% Deductible does not apply.	60% after 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		
	80% after Deductible has been met.	60% after Deductible has been met. *Prior Authorization is required.*
Ostomy Supplies		
Benefits are limited as follows: $2,500 per year	80% after Deductible has been met.	60% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	80% after Deductible has been met.	60% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met.	60% after Deductible has been met.
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.	*Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met.	60% after Deductible has been met. *Prior Authorization is required for Prosthetic Devices in excess of $1,000.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
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.	
		Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of Manipulative Treatments 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	100% after you pay a $20 Copayment per visit.	60% after Deductible has been met.
		Prior Authorization is required for certain services.
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.	80% after Deductible has been met.	60% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met.	60% after Deductible has been met.
		Prior Authorization is required.
Surgery - Outpatient		
	80% after Deductible has been met.	60% after 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 or other intravenous infusion therapy Radiation oncology	80% after Deductible has been met.	60% after Deductible has been met.
		Prior Authorization is required for certain services.

Types of Coverage	Network Benefits	Non-Network Benefits
Transplantation 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 Network Benefits, services must be received at a Designated Facility.	
	Prior Authorization is required.	*Prior Authorization is required.*

STATE SPECIFIC BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
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.	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Bones or Joints of the Jaw and Facial Region		
	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Cleft Lip/Cleft Palate Treatment		
	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	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.	
	Prior Authorization is required.	*Prior Authorization is required.*
Dental Services - Anesthesia and Hospitalization		
	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Enteral Formulas		
	80% after Deductible has been met.	60% after Deductible has been met.
	Prior Authorization is required as described in your Schedule of Benefits.	*Prior Authorization is required as described in your Schedule of Benefits.*
Mental Health Services		
	Inpatient: 80% after Deductible has been met.	Inpatient: 60% after Deductible has been met.
	Outpatient: 100% after you pay a $20 Copayment per visit.	Outpatient: 60% after Deductible has been met.
		Prior Authorization is required for certain services.

Types of Coverage	Network Benefits	Non-Network Benefits
Neurobiological Disorders – Autism Spectrum Disorder Services		
	Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a $20 Copayment per visit.	Inpatient: 60% after Deductible has been met. Outpatient: 60% after Deductible has been met. *Prior Authorization is required for certain services.*
Osteoporosis Treatment		
	80% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*	60% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*
Substance Use Disorder Services		
	Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a $20 Copayment per visit.	Inpatient: 60% after Deductible has been met. Outpatient: 60% after Deductible has been met. *Prior Authorization is required for certain services.*

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

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.

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.

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.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for R & T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities and Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

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

Neurobiological Disorders – Autism Spectrum Disorder

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

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

Nutrition

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

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

Enteral feedings, even if the sole source of nutrition. This exclusion does 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 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 Bones or Joints of the Jaw and Facial Region and Dental Services - Anesthesia and Hospitalization in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

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

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required to be paid by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

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

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

Transplants

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

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.

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 a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance 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®

YOUR BENEFITS

Benefit Summary

Florida - Choice
Balanced - 20/500/80% Plan 0M9 Modified

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **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 much, much 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.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits
Annual Deductible	
Individual Deductible	$500 per year
Family Deductible	$1,000 per year

> 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 more than the individual Deductible amount.

Out-of-Pocket Maximum	
Individual Out-of-Pocket Maximum	$2,500 per year
Family Out-of-Pocket Maximum	$5,000 per year

> All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.

> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

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

FLXA020M915 Modified
Item# Rev. Date
XXX-XXXX 0814_rev01 Base/Value/Sep/Emb/16035/2011/HMO

UnitedHealthcare of Florida, Inc.

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Contract or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid. In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits
Physician's Office Services - Sickness and Injury	
Primary Physician Office Visit	100% after you pay a $20 Copayment per visit.
Specialist Physician Office Visit	100% after you pay a $30 Copayment per visit.

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services

Covered Health Services include but are not limited to:

Primary Physician Office Visit	100%, Copayments and Deductibles do not apply.
Specialist Physician Office Visit	100%, Copayments and Deductibles do not apply.
Lab, X-Ray or other preventive tests	100%, Copayments and Deductibles do not apply.

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Urgent Care Center Services

100% after you pay a $75 Copayment per visit.

> In addition to the Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Emergency Health Services - Outpatient

100% after you pay a $200 Copayment per visit.

Notification is required if confined in a non-Network Hospital.

Hospital - Inpatient Stay

80% after Deductible has been met.

Types of Coverage	Network Benefits
Ambulance Service - Emergency and Non-Emergency	
Ground Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	80% after Deductible has been met.
Air Ambulance Transportation costs of a newborn to the nearest appropriate facility for treatment are covered.	80% after Deductible has been met.
	Prior Authorization is required for non-Emergency Ambulance.
Congenital Heart Disease (CHD) Surgeries	
	80% after Deductible has been met.
Dental Services - Accident Only	
	80% after Deductible has been met. *Prior Authorization is required.*
Diabetes Services	
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	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.
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.
Durable Medical Equipment	
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.	80% after Deductible has been met.
Habilitative Services	
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.
Hearing Aids	
Benefits are limited as follows: $2,500 per year and are further limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met.
Home Health Care	
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits
Hospice Care	
	80% after Deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient	
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	
Lab Testing - Outpatient	100% Deductible does not apply.
X-Ray and Other Diagnostic Testing - Outpatient	100% Deductible does not apply.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	80% after Deductible has been met.
Ostomy Supplies	
Benefits are limited as follows: $2,500 per year	80% after Deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications administered in an outpatient setting, in the Physician's Office, or in a Covered Person's home.	80% after Deductible has been met.
Physician Fees for Surgical and Medical Services	
	80% after Deductible has been met.
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.
Prosthetic Devices	
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met.
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.

Types of Coverage	Network Benefits
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	
Benefits are limited as follows: 20 visits of Manipulative Treatments 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	100% after you pay a $20 Copayment per visit.
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.	80% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Benefits are limited as follows: 60 days per year	80% after Deductible has been met.
Surgery - Outpatient	
	80% after Deductible has been met.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	80% after Deductible has been met.
Transplantation 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 Network Benefits, services must be received at a Designated Facility. *Prior Authorization is required.*

STATE SPECIFIC BENEFITS

Types of Coverage	Network Benefits
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.	80% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*
Bones or Joints of the Jaw and Facial Region	
	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. *Prior Authorization is required as described in your Schedule of Benefits.*
Cleft Lip/Cleft Palate Treatment	
	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. *Prior Authorization is required as described in your Schedule of Benefits.*
Clinical Trials	
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	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. *Prior Authorization is required.*
Dental Services - Anesthesia and Hospitalization	
	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. *Prior Authorization is required as described in your Schedule of Benefits.*
Enteral Formulas	
	80% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*
Mental Health Services	
	Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a $20 Copayment per visit.
Neurobiological Disorders – Autism Spectrum Disorder Services	
	Inpatient: 80% after Deductible has been met. Outpatient: 100% after you pay a $20 Copayment per visit.