UnitedHealthcare®

Benefit Summary

ASO Choice

McLennan County Medical Plan Name: Copay Plan

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

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

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **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.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Your cost if you use Network Benefits

Annual Deductible

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

- Your co-pays do not count towards meeting the deductible unless otherwise described within the specific covered health care service.
- All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	$2,000 per year.
Medical Deducible - Family	$4,000 per year.

Out-of-Pocket Limit

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

- Your co-pays, co-insurance, and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.
- All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

Out-of-Pocket Limit – Individual	$5,500 per year.
Out-of-Pocket Limit - Family	$11,00 per year.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Does a Medical Deductible Apply?
Ambulance Services		
Emergency Ambulance:	20% co-insurance	Yes
Non-Emergency Ambulance:	20% co-insurance	Yes
Cellular and Gene Therapy		
Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	Deductible will be based on where the covered health care service is provided.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Does a Medical Deductible Apply?
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	Deductible will be based on where the covered health care service is provided.
Congenital Heart Disease (CHD) Surgeries		
	Benefits will be the same as stated under Hospital - Inpatient Stay.	Deductible will be the same as stated under Hospital - Inpatient Stay.
Dental Services – Accident Only		
	20% co-insurance	Yes
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	Deductible will be based on where the covered health care service is provided.
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider.	
Durable Medical Equipment (DME), Orthotics and Supplies		
Replacements - Medically Necessary replacements for medical reasons and normal repairs.	20% co-insurance	Yes
Emergency Health Care Services - Outpatient		
	$250 co-pay per visit and 20% co-insurance Notification is required if confined in an Out-of-Network Hospital.	Yes
Enteral Nutrition		
	Not covered	Yes
Gender Dysphoria		
	Not covered	
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.	Deductible will be based on where the covered health care service is provided.
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.	$35 co-pay per visit	No
Hearing Aids		
Children under the age of 19 - $3000 per hearing impaired ear, replacement is based on anatomical growth and development. Over age 19 - $3000 per hearing impaired ear every 3 years.	20% co-insurance	Yes
Home Health Care		
	20% co-insurance	Yes
Hospice Care		
	20% co-insurance	Yes
Hospital – Inpatient Stay		
	20% co-insurance	Yes
Lab, X-Ray and Diagnostics - Outpatient		
Lab Testing – Outpatient Limited to 18 Presumptive Drug Tests per year and to 18 Definitive Drug Tests per year. X-Ray and Other Diagnostic Testing - Outpatient	*You pay nothing* *You pay nothing*	Network: No No

This Benefit Summary should only be used to highlight your Benefits. Do not use this document to understand your exact coverage, exclusions, and limitations. If this Benefit Summary conflicts with the Summary Plan Description (SPD), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage. This material is provided on the recipient's agreement that it will only be used for the purpose of describing United HealthCare Services, Inc.'s products and services to the recipient. Any other use, copying or distribution without the express written permission of United HealthCare Services, Inc. is prohibited.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Does a Medical Deductible Apply?
Major Diagnostic and Imaging - Outpatient		
	20% co-insurance	Yes
Mental Health Care and Substance – Related and Addictive Disorders Services		
Inpatient:	20% co-insurance	Yes
Outpatient:	$35 co-pay per visit	No
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance	Yes
Ostomy Supplies		
	20% co-insurance	Yes
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	20% co-insurance	Yes
Physician Fees for Surgical and Medical Services		
	20% co-insurance	Yes
Physician's Office Services – Sickness and Injury		
Primary Care Physician Office Visit:	Covered persons less than age 19: You pay nothing All other covered persons: $35 co-pay per visit	No
Specialist Office Visit:	$55 co-pay per visit	No
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office.		
Pregnancy – Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Deductible will be based on where the covered health care service is provided.
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing	No
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Replacements due solely to growth, other Medically Necessary replacements for medical reasons and normal repairs.	20% co-insurance	Yes
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	Deductible will be based on where the covered health care service is provided.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 Manipulative Treatments 20 visits of speech therapy 20 visits of pulmonary rehabilitation therapy 36 visits of cardiac rehabilitation therapy 30 visits of post-cochlear implant aural therapy	$35 co-pay per visit	No
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance	Yes
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
.	20% co-insurance	Yes
Surgery – Outpatient		
	20% co-insurance	Yes
Therapeutic Treatments – Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance	Yes
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	Deductible will be based on where the covered

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Does a Medical Deductible Apply?
		health care service is provided.
Urgent Care Center Services		
	$75 co-pay per visit	No
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility.		
Urinary Catheters		
	20% co-insurance	Yes
Virtual Visits		
Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	You pay nothing	No

Additional Covered Health Care Services	Your cost if you use Network Benefits	Does a Medical Deductible Apply?
Obesity – Weight Loss Surgery		
Obesity surgery is covered when received at a designated facility and performed by a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions. Benefits are limited to one surgery per lifetime.	The amount you pay is based on where the covered health care service is provided.	Deductible will be based on where the covered health care service is provided.
Vision Exams		
Limited to 1 exam every year.	$35 co-pay per visit	No
Wigs		
Limited to $1,000 every year	20% co-insurance	Yes

Exclusions and Limitations

This is a partial list of services that your plan generally does not cover. It does not include all of the services that are not covered. It is important that you review Section 2: Exclusions and Limitations in your Summary Plan Description 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.

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Temporomandibular Joint Services
- Weight Loss Programs
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For Internal Use Only:
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BASE/VALUE

UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសុំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jiik'eh, bee ná'ahóót'i'. T'áá shoodi nínaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jiik'ehgo béésh bee hane'í bika'ígíí bee hodiilnih.

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