PPO Medical Plan

UnitedHealthcare®

Benefit Summary
ASO Options PPO
Sheehy Auto Stores Medical 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 Sheehy Auto Stores want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

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

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

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible Family Deductible	$1,000 per year $2,000 per year	$1,000 per year $2,000 per year
• Member Copayments do not accumulate towards the Deductible unless otherwise notated within the specific benefit category below.		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$4,000 per year $8,000 per year	$4,000 per year $8,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug Out-of-Pocket Maximum is not included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	85% after Deductible has been met	80% after Deductible has been met
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover.		
Information of Prior Authorization		
**Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)* ***Prior Authorization is required for Equipment in excess of $1,000.*		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. • In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 100% after a $500 copay	* 100% after a $500 copay
Dental Services – Accident Only		
	* 85% after Deductible has been met*	* 85% after Network Deductible has been met
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.	** 85% after Deductible has been met	** 80% after Deductible has been met
Emergency Health Services - Outpatient		
	* 100% after you pay a $250 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	* 100% after you pay a $250 Copayment per visit

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BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/replacement) every three years.	85% after Deductible has been met	80% after Deductible has been met
Home Health Care		
Benefits are limited as follows: Limited to 52 visits per year	* 85% after Deductible has been met	* 80% after Deductible has been met
Hospice Care		
	* 85% after Deductible has been met	* 80% after Deductible has been met
Hospital – Inpatient Stay		
	* 85% after Deductible has been met	* 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.	85% after Deductible has been met.	80% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	85% after Deductible has been met	80% after Deductible has been met
Mental Health Services		
Inpatient Outpatient	* 85% after Deductible has been met * 100% after you pay a $40 Copayment per visit	* 80% after Deductible has been met * 80% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
Inpatient Outpatient	* 85% after Deductible has been met * 100% after you pay a $40 Copayment per visit	* 80% after Deductible has been met * 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.	85% after Deductible has been met	80% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	85% after Deductible has been met	80% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	* 100% after you pay a $30 Copayment per visit	* 80% after Deductible has been met
Specialist Physician Office Visit	* 100% after you pay a $40 Copayment per visit	* 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.	
Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.		
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	** 85% after Deductible has been met	** 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.	
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 52 visits of physical therapy 52 visits of occupational therapy 52 visits of speech therapy 52 visits of pulmonary rehabilitation 52 visits of cardiac rehabilitation 60 visits of Vision Therapy (Orthoptic) 52 visits of cognitive rehabilitation therapy 12 visits of manipulative treatment	100% after you pay a $30 Copayment per visit 85% after Deductible has been met	80% after Deductible has been met 80% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Services category.	85% after Deductible has been met	80% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	* 85% after Deductible has been met	* 80% after Deductible has been met
Substance Use Disorder Services		
Inpatient Outpatient	* 85% after Deductible has been met * 100% after you pay a $40 Copayment per visit	* 80% after Deductible has been met * 80% after Deductible has been met