HSA (POS) Medical Plan

Benefit Summary
ASO Choice Plus
Sheehy Auto Sales HSA 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 – Combined Medical and Pharmacy		
Single Coverage Deductible Family Coverage Deductible	$1,600 per year $3,200 per year	$3,000 per year $6,000 per year
• No one in the family is eligible for benefits until the family coverage deductible is met.		
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Single Coverage Out-of-Pocket Maximum Family Coverage Out-of-Pocket Maximum	$6,450 per year $6,550 per year	$12,900 per year $25,800 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. • Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	90% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.		
Information of Pre-service 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		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Dental Services – Accident Only		
	90% after Deductible has been met	90% 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.	90% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	90% after Deductible has been met	90% after Network Deductible has been met

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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.	90% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: Limited to 52 visits per year	90% after Deductible has been met	* 70% after Deductible has been met
Hospice Care		
	90% after Deductible has been met	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	90% after Deductible has been met	* 70% 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.	90% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	90% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
Inpatient Outpatient	90% after Deductible has been met 90% after Deductible has been met	* 70% after Deductible has been met * 70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
Inpatient Outpatient	90% after Deductible has been met 90% after Deductible has been met	* 70% after Deductible has been met * 70% 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.	90% after Deductible has been met	70% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	90% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	90% after Deductible has been met	* 70% 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.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	90% after Deductible has been met	** 70% 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.	
		Prior Authorization is required.
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	90% after Deductible has been met	70% 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.	90% after Deductible has been met	70% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: Limited to 60 days per year	90% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
Inpatient Outpatient	90% after Deductible has been met 90% after Deductible has been met	* 70% after Deductible has been met * 70% after Deductible has been met
Surgery – Outpatient		
	90% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* For Network Benefits, services must be received at a UHC Center of Excellence	Non-Network Benefits are not available
Urgent Care Center Services		
	90% after Deductible has been met	70% after Deductible has been met