UnitedHealthcare®

Benefit Summary

ASO Choice Plus
Grange Insurance Choice CDHP Medical Plan – Active

United HealthCare Services, Inc. and Grange Insurance 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	Your cost if you use Out-of-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. • No one in the family is eligible for benefits until the family coverage deductible is met. • Dollars applied to the Network Deductible also apply to the Non-Network Deductible and vice-versa (cross apply).		
Medical Deductible – Individual	$3,100 per year.	$6,200 per year.
Medical Deductible - Family	$6,200 per year.	$12,400 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-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit. • If more than one person in a family is covered under the Policy, the individual out-of-pocket limit does not apply. • Dollars applied to the Network Out-of-Pocket Limit also apply to the Non-Network Out-of-Pocket Limit and vice-versa (cross apply).		
Out-of-Pocket Limit – Individual	$4,300 per year.	$8,600 per year.
Out-of-Pocket Limit – Family	$8,600 per year.	$17,200 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	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Ambulance Services			
Emergency Ambulance:	80% co-insurance	Same as Network.	Network: Yes Out-of-Network: Yes Network Deductible applies to Out-of-Network benefits.
Non-Emergency Ambulance:	80% co-insurance Prior Authorization is required for Non-Emergency Ambulance.	Same as Network. Prior Authorization is required for Non-Emergency Ambulance.	
Clinical Trials			
	80% co-insurance Prior Authorization is required.	60% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Congenital Heart Disease (CHD) Surgeries			
	80% co-insurance	60% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Dental Services – Accident Only			
	80% co-insurance Prior Authorization is required.	Same as Network. Prior Authorization is required.	Network: Yes Out-of-Network: Yes Network Deductible applies to Out-of-Network benefits.

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	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
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.		Network: Yes Out-of-Network: Yes
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.		
		Prior Authorization is required for DME that costs more than $1,000.	
Durable Medical Equipment (DME) , Orthotics and Supplies			
Limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required for DME or orthotics that costs more than $1,000.	
Emergency Health Services - Outpatient			
	80% co-insurance	Same as Network.	Network: Yes Out-of-Network: Yes Network Deductible applies to Out-of-Network benefits.
		Notification is required if confined in an Out-of-Network Hospital.	
Gender Dysphoria			
	The amount you pay is based on where the covered health care service is provided.		Network: Yes Out-of-Network: Yes
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.	
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.	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive 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.	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required for certain services.	
Hearing Aids			
Limited to $2,500 every year. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Home Health Care			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes

Your Costs

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.		Prior Authorization is required.	
Hospice Care			
	80% co-insurance	60% co-insurance Prior Authorization is required for Inpatient Stay.	Network: Yes Out-of-Network: Yes
Hospital – Inpatient Stay			
	80% co-insurance	60% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
X-Ray and Other Diagnostic Testing - Outpatient	80% co-insurance	60% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Major Diagnostic and Imaging - Outpatient			
	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Mental Health Care and Substance – Related and Addictive Disorders Services			
Inpatient:	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Outpatient:	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Partial Hospitalization/Intensive Outpatient Treatment:	80% co-insurance	60% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Ostomy Supplies			
	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Pharmaceutical Products - Outpatient			
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Physician Fees for Surgical and Medical Services			
	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Physician's Office Services – Sickness and Injury			
Primary Care Physician Office Visit:	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Specialist Office Visit:	80% co-insurance	60% co-insurance Prior Authorization is required for Genetic Testing.	Network: Yes Out-of-Network: Yes
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	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.	Network: Yes Out-of-Network: Yes
Preventive Care Services			
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing	60% co-insurance	Network: No Out-of-Network: Yes

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.

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Prosthetic Devices			
Limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	80% co-insurance	60% co-insurance Prior Authorization is required for Prosthetic Devices that costs more than $1,000.	Network: Yes Out-of-Network: Yes
Reconstructive Procedures			
	80% co-insurance	60% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment			
Benefits are limited as follows: 60 combined annual visits for physical therapy, speech therapy, pulmonary rehabilitation and occupational therapy. 25 visits of Manipulative Treatment 36 visits of cardiac rehabilitation therapy 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Scopic Procedures – Outpatient Diagnostic and Therapeutic			
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services			
Limited to 90 days per year.	80% co-insurance	60% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Surgery – Outpatient			
	80% co-insurance	60% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Therapeutic Treatments – Outpatient			
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	80% co-insurance	60% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Transplantation Services			
Network Benefits must be received from a Designated Provider.	80% co-insurance Prior Authorization is required.	60% co-insurance	Network: Yes Out-of-Network: Yes
Urgent Care Center Services			
	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: Yes
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility.			
Virtual Visits			
Network 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.	80% co-insurance	Out-of-Network Benefits are not available.	Network: Yes Out-of-Network: Out-of-Network Benefits are not available.

Additional Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Infertility Services			
Limited to $25,000 per lifetime for employee and spouse combined.	80% co-insurance Prior Authorization is required.	60% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Obesity – Weight Loss Surgery			
Obesity surgery is covered if the member has a BMI or greater than 40; or the member has a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by the obesity.	80% co-insurance Prior Authorization is required.	60% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Private Duty Nursing			
Provided on an outpatient basis by a licensed nurse such as a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN). Limited to any combination of Network and Non-Network benefits of 70 shifts per year.	80% co-insurance	60% co-insurance	
Temporomandibular Joint Services			
	80% co-insurance	60% co-insurance Prior Authorization is required for Inpatient Stay.	Network: Yes Out-of-Network: Yes
Vision Exams			
Limited to 1 exam every plan year	80% co-insurance	Not Covered	Network: Yes Out-of-Network: Not Covered
Wigs			
Limited to $1,000 every plan year For medical conditions from cancer treatment to alopecia.	80% co-insurance	60% co-insurance	Network: Yes Out-of-Network: 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
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Weight Loss Programs

For Internal Use Only:
SFXABXXTTT18

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 हैं, 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 គឺមានសំរាប់អ្នក។ សមទ្រសពុទ្ធៅលេខឥតគិតថ្លៃ 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 jíík'eh, bee ná'ahóót'i'. T'áá shoodí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í bikáʼígíí 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.

This Benefit Summary should only be used to highlight your Benefits. Don't 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.