



**Benefit Summary**  
**ASO Choice Plus HSA**  
**THE CITY OF DUBLIN Medical Plan**  
**Non-Union**

**UnitedHealthcare and The City of Dublin 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 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.

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
<b>Annual Deductible – Combined Medical and Pharmacy</b>		
Individual Deductible	\$2,500 per year	\$5,000 per year
Family Deductible	\$5,000 per year	\$10,000 per year
No one in the family is eligible for benefits until the family coverage deductible is met.		
<b>Out-of-Pocket Maximum – Combined Medical and Pharmacy</b>		
Individual Out-of-Pocket Maximum	\$4,000 per year	\$8,000 per year
Family Out-of-Pocket Maximum	\$8,000 per year	\$16,000 per year
<ul style="list-style-type: none"> <li>• The Out-of-Pocket Maximum includes the Annual Deductible.</li> <li>• 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.</li> </ul>		
<b>Benefit Plan Coinsurance – The Amount the Plan Pays</b>		
	85% after Deductible has been met	60% after Deductible has been met
<b>Lifetime Maximum Benefit</b>		
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	No Lifetime Maximum Benefit	No Lifetime Maximum Benefit
<b>Prescription Drug Benefits</b>		
<ul style="list-style-type: none"> <li>• Prescription drug benefits are shown under separate cover.</li> </ul>		
<b>Information of Pre-service Notification</b>		
*Pre-service Notification is required for certain services.		
**Pre-service Notification is required for Equipment in excess of \$1,000.		
<b>Information on Benefit Limits</b>		
<ul style="list-style-type: none"> <li>• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.</li> <li>• All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description.</li> <li>• When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.</li> </ul>		

**BENEFITS**

Types of Coverage	Network Benefits	Non-Network Benefits
<b>Acupuncture</b>		
	85% after Deductible has been met	Same as Network
<b>Ambulance Services – Emergency and Non-Emergency</b>		
	* 85% after Deductible has been met	* Same as Network
<b>Dental Services – Accident Only</b>		
	* 85% after Deductible has been met	* Same as Network
<b>Durable Medical Equipment (DME)</b>		
	85% after Deductible has been met	** 60% after Deductible has been met

THIS MATERIAL IS PROVIDED ON THE RECIPIENT'S AGREEMENT THAT IT WILL ONLY BE USED FOR THE PURPOSE OF DESCRIBING UNITEDHEALTHCARE'S PRODUCTS AND SERVICES TO THE RECIPIENT. ANY OTHER USE, COPYING OR DISTRIBUTION WITHOUT THE EXPRESS WRITTEN PERMISSION OF UNITEDHEALTHCARE IS PROHIBITED.

<b>BENEFITS</b>		
Types of Coverage	Network Benefits	Non-Network Benefits
<b>Emergency Health Services - Outpatient</b>		
	* 85% after Deductible has been met	* Same as Network
<b>Hearing Aids</b>		
Benefits are limited as follows: \$5,000 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	85% after Deductible has been met	60% after Deductible has been met
<b>Home Health Care</b>		
Network and Non-Network Benefits are limited to 100 visits for skilled care services per calendar year.	85% after Deductible has been met	* 60% after Deductible has been met
<b>Hospice Care</b>		
Network and Non-Network benefits are limited to 180 days during the entire period of time a Covered Person is covered under the plan.	85% after Deductible has been met	* 60% after Deductible has been met
<b>Hospital – Inpatient Stay</b>		
	85% after Deductible has been met	* 60% after Deductible has been met
<b>Lab, X-Ray and Diagnostics - Outpatient</b>		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	85% after Deductible has been met	60% after Deductible has been met
<b>Lab, X-Ray and Major Diagnostics – CT, PET, MRI and Nuclear Medicine - Outpatient</b>		
	85% after Deductible has been met	60% after Deductible has been met
<b>Mental Health Services</b>		
	85% after Deductible has been met	* 60% after Deductible has been met
<b>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</b>		
	85% after Deductible has been met	* 60% after Deductible has been met
<b>Nutritional Counseling</b>		
	85% after Deductible has been met	60% after Deductible has been met
<b>Pharmaceutical Products - Outpatient</b>		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	85% after Deductible has been met	60% after Deductible has been met
<b>Physician Fees for Surgical and Medical Services</b>		
	85% after Deductible has been met	60% after Deductible has been met
<b>Physician's Office Services – Sickness and Injury</b>		
<b>Primary Physician Office Visit</b>	85% after Deductible has been met	60% after Deductible has been met
<b>Specialist Physician Office Visit</b>	85% after Deductible has been met	60% after Deductible has been met
<b>Pregnancy – Maternity Services</b>		
	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.	
		<i>Pre-service Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
<b>Preventive Care Services</b>		
Covered Health Services include but are not limited to:		
<b>Primary Physician Office Visit</b>	100% Deductible does not apply.	Non-Network Benefits are not available
<b>Specialist Physician Office Visit</b>	100% Deductible does not apply.	
<b>Lab, X-Ray or other preventive tests</b>	100% Deductible does not apply.	
<b>Prosthetic Devices</b>		
	85% after Deductible has been met	60% after Deductible has been met

<b>BENEFITS</b>		
Types of Coverage	Network Benefits	Non-Network Benefits
<b>Reconstructive Procedures</b>		
	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.	
		<i>Pre-service Notification is required for certain services.</i>
<b>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment</b>		
Benefits are limited as follows: 24 visits of physical therapy 24 visits of occupational therapy 40 visits of manipulative treatment 24 visits of speech therapy 24 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 20 visits of cognitive therapy Additional visits may be authorized by the plan administrator based on medical necessity & physician documentation.	85% after Deductible has been met	60% after Deductible has been met
<b>Scopic Procedures – Outpatient Diagnostic and Therapeutic</b>		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	100% Deductible does not apply.	60% after Deductible has been met
<b>Skilled Nursing Facility / Inpatient Rehabilitation Facility Services</b>		
Network and Non-Network Benefits are limited to 60 days per calendar year.	85% after Deductible has been met	* 60% after Deductible has been met
<b>Substance Use Disorder Services</b>		
	85% after Deductible has been met	* 60% after Deductible has been met
<b>Surgery – Outpatient</b>		
	85% after Deductible has been met	60% after Deductible has been met
<b>Temporomandibular Joint Disorder (TMJ)</b>		
	85% after Deductible has been met	60% after Deductible has been met
<b>Transplantation Services</b>		
	85% after Deductible has been met	* 60% after Deductible has been met
	<i>For Network Benefits, services must be received at a Designated Facility.</i>	
<b>Urgent Care Center Services</b>		
	85% after Deductible has been met	60% after Deductible has been met
<b>Morbid Obesity Surgery</b>		
Network and Non-Network Benefits are limited to a \$25,000 lifetime maximum. Member must be enrolled in a 6 month diet and exercise program before considered eligible.	85% after Deductible has been met	* 60% after Deductible has been met
<b>Foot Orthotics</b>		
Orthotics limited to \$200 over a 5 year period.	85% after Deductible has been met	60% after Deductible has been met

<b>MEDICAL EXCLUSIONS</b>
<b>A. Alternative Treatments</b> Acupressure; hypnosis; rolfing; massage therapy; aromatherapy; and other forms of alternative treatment.
<b>B. Comfort or Convenience</b> Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.
<b>C. Dental</b> Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.
<b>D. Drugs</b> Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.
<b>E. Experimental, Investigational or Unproven Services</b> Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, 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, Investigational or Unproven in the treatment of that particular condition.
<b>F. Foot Care</b> Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot.

#### **G. Medical Supplies and Appliances**

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings and diabetic test strips. Some types of orthotics, including cranial banding and some types of braces. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

#### **H. Mental Health/Substance Abuse**

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

#### **I. Nutrition**

Megavitamin and nutrition based therapy. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

#### **J. Physical Appearance**

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, when the hair loss is not a result of a medical treatment.

#### **K. Providers**

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

#### **L. Reproduction**

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization. Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy or missed abortion (commonly known as a miscarriage).

#### **M. Services Provided under Another Plan**

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness 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.

#### **N. Transplants**

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

#### **O. 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 transplantation services may be reimbursed at our discretion.

#### **P. Vision**

Purchase cost of eye glasses or contact lenses. Fitting charge for eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

#### **Q. Other Exclusions**

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) 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.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

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 Plan.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea.

Non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.