This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in your medical policy. If there is a difference between this summary and your policy, the terms of your policy will apply.

Providers, this summary is for members, to review the terms of your participation agreement, please visit

SITUATION	CHOICE PLUS HSA NETWORK	CHOICE PLUS HSA NON-NETWORK
Acupuncture services for pain therapy when the following is true: ● The service is performed in an office setting by a Provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: in the Provider's office. ● Doctor of Medicine; ● Doctor of Osteopathy; ● Chiropractor; or ● Acupuncturist. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of nausea as a result of: ● Chemotherapy; ● Pregnancy; and · Post-operative procedures.	**80%** of eligible expenses after satisfying the deductible. Any combination of Network and Non-Network Benefits is limited to **12** treatments per calendar year.	**60%** of eligible expenses after satisfying the deductible. Any combination of Network and Non-Network Benefits is limited to **12** treatments per calendar year.

	80% of eligible expenses after satisfying the deductible.	**60%** of eligible expenses after satisfying the deductible.
(BRS)	Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence. Access the Bariatric Resource Services Centers of Excellence programs at **1-888-936-7246** or by clicking . All authorization information and enrollment for bariatric surgery must be initiated through United Resource Networks (U.R.N.). Covered participants seeking coverage for bariatric surgery should obtain prior authorization U.R.N. as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling U.R.N., at **1-888-936-7246** to enroll in the program. You are required to participate in the Surgery Decision Support (SDS) Program, provided by Consumer Medical, if your physician recommends any of the following surgeries: · Bariatric (weight loss) Surgery, · Hysterectomy, · Knee Replacement, · Hip Replacement, · Low Back Surgery Failure to complete the program will result in a **$1,000** penalty. Call **1-888-361-3944** to enroll and speak with an SDS program specialist.	
Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of	**100%** of eligible expenses.	**60%** of eligible expenses after satisfying the deductible.

purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider or Physician.		
	Not Applicable	
What are clinical trials? A research study that tests new treatments on patients. We cover some routine patient costs for participation in an approved clinical trial if: · You meet the requirements to participate; and · You are referred by a network provider who has said based on medical and scientific information the clinical trial is appropriate for your condition · You have received prior authorization from us. **What is an approved clinical trial?** A clinical trial that is: · Federally funded or approved; and · Conducted under an investigational drug application reviewed by the Food and Drug Administration (FDA). For all other clinical trials there is no coverage. No coverage for: · Cost for investigational drugs or devices.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category. Pre-service **Authorization Requirement** You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category. Pre-service **Authorization Requirement** You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.

· Cost for non-health services (for example: travel/transportation) required for you to receive the treatment. · Cost for managing the research. · Items and services provided by the research sponsor free of charge for any person enrolled in the trial. **Want more information?** View the for definitions.		
	80% of eligible expenses after satisfying the deductible Access to the CHD Centers of Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in treating Congenital Heart Disease. Potential benefits include accurate diagnosis, appropriate surgical interventions, higher survival rates and decreased costs. Network benefits are available for patients who receive care at a designated CHD Centers of Excellence Network facility. Participation in this program is voluntary for the enrollee. To help ensure network benefits are received under this program, patients, or someone on their behalf, should contact CHD Resource Services at **1-888-936-7246** before receiving care. More information is also available .	**60%** of eligible expenses after satisfying the deductible Access to the CHD Centers of Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in treating Congenital Heart Disease. Potential benefits include accurate diagnosis, appropriate surgical interventions, higher survival rates and decreased costs. Network benefits are available for patients who receive care at a designated CHD Centers of Excellence Network facility. Participation in this program is voluntary for the enrollee. To help ensure network benefits are received under this program, patients, or someone on their behalf, should contact CHD Resource Services at **1-888-936-7246** before receiving care. More information is also available .

	Travel and Lodging Assistance is available as part of the Congenital Heart Disease Resource Services program. **$50/$100** per diem with a Lifetime Maximum of **$10,000**. **Prior Authorization Requirement** Please remember that for Benefits you must obtain prior authorization before receiving services.	**Prior Authorization Requirement** Please remember that for Benefits you must obtain prior authorization before receiving services.
Dental services are covered by the Plan when all of the following are true: · treatment is necessary because of accidental damage; · dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth; · dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and · the dental damage is severe enough that initial contact with a Physician or dentist occurs within **72** hours of the accident. (You may request an extension of this time period provided that you do so within **60** days of the Injury and if extenuating circumstances exist due to the severity of the Injury) The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical	**80%** of eligible expenses after satisfying the deductible	**80%** of eligible expenses after satisfying the Network deductible

elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate

Dental services for final treatment to repair the damage caused by accidental Injury must be started within **3** months of the accident or from the time you are covered on the plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within **12** months of the accident or from the time you are covered on the plan.

The Plan pays for treatment of accidental Injury only for:

- emergency examination
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and

- replacement of lost teeth due to the Injury by implant, dentures or bridges.

The following services are not covered:

- Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
- Endodontics, periodontal surgery and restorative treatment.
- Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include
  - extractions (including wisdom teeth);
  - restoration and replacement of teeth;
  - medical or surgical treatments of dental conditions; and
  - services to improve dental clinical outcomes;
- dental implants, bone grafts, and other implant-related procedures;
- dental braces (orthodontics);
- dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia (This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral

infection) required for the direct treatment of a medical condition for which Benefits are available as described above; and ● treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.		
The plan pays for Durable Medical Equipment that is: ● Ordered or provided by a Physician for outpatient use; ● Used for medical purposes; ● Not consumable or disposable; ● Not of use to a person in the absence of a sickness, injury or disability; ● Durable enough to withstand repeated use; and · Appropriate for use in the home. If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the	**80%** of eligible expenses after satisfying the deductible**.** Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every **3** calendar years. Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.	**80%** of eligible expenses after satisfying the Network deductible**.** Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every **3** calendar years. Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. **Prior Authorization Required** Please remember that for Benefits you must obtain prior authorization before obtaining any single item of Durable Medical Equipment that costs more than **$1,000** (purchase, rental, repair or replacement of Durable Medical Equipment).

piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under ***Diabetes Services;***
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

In addition to other Shoe/Shoe Orthotics, Diabetic specific shoes and inserts are always covered. The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with Durable Medical Equipment. Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.		
Benefits include: · Psychotherapy · Continuous hormone replacement · Genital surgery and surgery to change secondary sex characteristics · Laboratory testing to monitor the safety of continuous hormone therapy · Reversal for a gender reassignment surgery · Travel & Lodging	**Same as** · *Physician's Office Services – Sickness and Injury* · *Physician Fees* · Hospital-Inpatient Stay · Surgery - Outpatient · *Lab, X-ray and Diagnostics – Outpatient*	**Same as** · *Physician's Office Services – Sickness and Injury* · *Physician Fees* · Hospital-Inpatient Stay · Surgery - Outpatient · *Lab, X-ray and Diagnostics – Outpatient* **Prior Authorization Required** For benefits you must obtain prior authorization **5** business days before scheduled services are received or, for non-scheduled services, within **1** business day or as soon as is reasonably possible.
	Not Applicable	
	80% of eligible expenses after satisfying the deductible**.**	**60%** of eligible expenses after satisfying the deductible.

The Plan pays Benefits for hearing aids which are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Only covers Hearing Aids furnished to a covered dependent child up to age **26.**

No benefit limit to purchase frequency (including repair/replacement). Limited to **1** exam every two calendar years.		
	Not Applicable	
Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be: ● ordered by a Physician; ● provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse; ● not considered Custodial Care, as defined in Glossary; and ● provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Glossary for the definition of Skilled Care. We will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver Skilled care is skilled nursing, teaching, and rehabilitation services when: ● They are delivered or	**80%** of eligible expenses after satisfying the deductible**.** **The following services are not covered:** ● Custodial Care. ● Domiciliary care. ● Respite care. ● Rest cures. Any combination of Network and Non-Network Benefits is limited to **120** visits per calendar year. One visit equals **8** hours of skilled home health care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	**60%** of eligible expenses after satisfying the deductible**.** **The following services are not covered:** ● Custodial Care. ● Domiciliary care. ● Respite care. ● Rest cures. Any combination of Network and Non-Network Benefits is limited to **120** visits per calendar year. One visit equals **8** hours of skilled home health care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. **Prior Authorization Required** Please remember that for Benefits you should obtain prior authorization **5** business days before receiving services.

• They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; • A physician orders them; • They are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair; • They require clinical training in order to be delivered safely and effectively; and • They are not Custodial Care. Custodial Care is defined as services that do not require special skills or training and that: • Provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating); • Do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or • Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.		
	80% of eligible expenses after satisfying the deductible.	**60%** of eligible expenses after satisfying the deductible.

Hospice Care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are only available when hospice care is received from a licensed hospice agency, which can include a Hospital.		**Prior Authorization Required** Please remember that for Benefits you should obtain prior authorization **5** business days before receiving services.
	Not Applicable	
Initial pair of eyeglasses or contact lenses following a medically necessary cataract surgical procedure.	**80%** of eligible expenses after satisfying the deductible	**60%** of eligible expenses after satisfying the deductible
	Not Applicable	
Benefits for ostomy supplies are limited to: ● Pouches, face plates and belts. ● Irrigation sleeves, bags and ostomy irrigation catheters. ● Skin barriers. Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.	**80%** of eligible expenses after satisfying the deductible	**80%** of eligible expenses after satisfying the Network deductible

not listed above.		
The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category include: ● Antibiotic injections in the Physician's office or ● inhaled medication in an urgent care center for treatment of an asthma attack. Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy Benefits under this section do not include medications for the treatment of infertility. If the service is provided in a doctor's office, additional co-pays, deductible or co-insurance may apply.	**80%** of eligible expenses after satisfying the deductible.	**60%** of eligible expenses after satisfying the deductible.
	80% of eligible expenses after satisfying the deductible.	**60%** of eligible expenses after satisfying the deductible.

The Plan covers private duty nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).	Any combination of Network and Non-Network Benefits is limited to **120** visits per calendar year **The following service is not covered:** ● Private duty nursing received on an inpatient basis.	Any combination of Network and Non-Network Benefits is limited to **120** visits per calendar year **The following service is not covered:** ● Private duty nursing received on an inpatient basis.
Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to: ● artificial arms, legs, feet and hands; ● artificial face, eyes, ears and nose; ● breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of **1998**, including mastectomy bras and lymphedema stockings for the arm. Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses If more than **1** prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds	**80%** of eligible expenses after satisfying the deductible. Benefits are provided for the replacement of a type of prosthetic device once every **3** calendar years. At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the **3** year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of **1998**	**80%** of eligible expenses after satisfying the Network deductible. Benefits are provided for the replacement of a type of prosthetic device once every **3** calendar years. At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the **3** year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of **1998** **Prior Authorization** Required

prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost		Please remember that for Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed **$1,000** in cost per device.
Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance. Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of **1998**, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.	**Same as** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • **Hospital-Inpatient Stay** • **Surgery - Outpatient** • ***Lab, X-ray and Diagnostics – Outpatient*** • **Therapeutic Treatments - Outpatient** You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy related services.	**Same as** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • **Hospital-Inpatient Stay** • **Surgery - Outpatient** • ***Lab, X-ray and Diagnostics – Outpatient*** • **Therapeutic Treatments - Outpatient** You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy related services. **Prior Authorization** Required For Benefits you must obtain prior authorization **5** business days before a scheduled reconstructive procedure is performed. When you obtain prior authorization, we can determine whether the service is considered reconstructive or cosmetic. Cosmetic procedures are always excluded from coverage.

mastectomy-related services. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure **Note:** See exclusions described under **Physical Appearance**.		
Short-term outpatient rehabilitation services for: ● Physical therapy; ● Occupational therapy; ● Manipulative treatment ● Speech therapy; ● Post-cochlear implant aural therapy; ● Vision therapy ● Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident; ● Pulmonary rehabilitation therapy; and ● Cardiac rehabilitation therapy. For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services.	**80%** of eligible expenses after satisfying the deductible. Any combination of Network and Non-Network Benefits is limited as follows: · **45** visits of physical therapy per calendar year. Limit does not apply to Autism diagnosis. Habilitation is included in the visit maximum. · **45** visits of occupational therapy per calendar year. Limit does not apply to Autism diagnosis. Habilitation is included in the visit maximum. · **30** visits of manipulative treatment per calendar year	**60%** of eligible expenses after satisfying the deductible. Any combination of Network and Non-Network Benefits is limited as follows: · **45** visits of physical therapy per calendar year. Limit does not apply to Autism diagnosis. Habilitation is included in the visit maximum. · **45** visits of occupational therapy per calendar year. Limit does not apply to Autism diagnosis. Habilitation is included in the visit maximum. · **30** visits of manipulative treatment per calendar year · **45** visits of speech therapy per calendar year. Limit does not apply to Autism diagnosis

		apply to Autism diagnosis.
Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment. If the service is provided in a doctor's office, additional co-pays, deductible or co-insurance may apply.	· **45** visits of speech therapy per calendar year. Limit does not apply to Autism diagnosis. Habilitation is included in the visit maximum. · **Unlimited** visits of post-cochlear implant aural therapy per calendar year · **Unlimited** visits of vision therapy per calendar year. Only covered following surgery to the muscles controlling the eye or in treatment of the strabismus. · **Unlimited** visits of cognitive rehabilitation therapy per calendar year. · **Unlimited** visits of pulmonary rehabilitation therapy per calendar year. · **Unlimited** visits of cardiac rehabilitation therapy per calendar year.	Habilitation is included in the visit maximum. · **Unlimited** visits of post-cochlear implant aural therapy per calendar year · **Unlimited** visits of vision therapy per calendar year. Only covered following surgery to the muscles controlling the eye or in treatment of the strabismus. · **Unlimited** visits of cognitive rehabilitation therapy per calendar year. · **Unlimited** visits of pulmonary rehabilitation therapy per calendar year. · **Unlimited** visits of cardiac rehabilitation therapy per calendar year.
Benefits include: Non-Physician services and supplies received during the Inpatient Stay; Room and board in a semi-private room (a room with two or more beds).	**80%** of eligible expenses after satisfying the deductible. Any combination of Network and Non-Network Benefits is limited to **120** days per calendar year.	**60%** of eligible expenses after satisfying the deductible. Any combination of Network and Non-Network Benefits is limited to **120** days per calendar year. **Prior Authorization Required**

Benefits for other Physician services, are described under ***Physician Fees for Surgical and Medical Services*.**

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver
Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;

Prior Authorization Required

Please remember that you must obtain prior authorization as follows:

- For elective admissions: **5** business days before admission.
- For Emergency admissions (also termed non-elective admission): within **48** hours or as soon as is reasonably possible.

● it is ordered by a Physician; ● it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and ● it requires clinical training in order to be delivered safely and effectively. **The following services are not covered:** ● Custodial Care. ● Domiciliary care.		
	Not Applicable	
Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network Provider and received at a Centers of Excellence Facility for network benefits to apply. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which benefits are available include but are not limited to: · Heart; · Heart/lung; · Lung; · Kidney; · Kidney/pancreas; · Liver; · Liver/kidney; · Liver/intestinal; · Pancreas;	**Centers of Excellence (COE) Transplant Access Program (TAP)** **80%** of eligible expenses after satisfying the deductible **Travel and Lodging** We will assist the patient and family with travel and lodging arrangements related to: · Congenital Heart Disease (CHD); and · Transplantation services. For travel and lodging services to be covered, the patient must be receiving services at a Centers of Excellence Facility. The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:	**UHC Network** **60%** of eligible expenses after satisfying the deductible**.** **Pre-service Authorization Requirement** For Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

· Pancreas; · Intestinal; and · Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Benefits are also available for cornea transplants. We do not require that cornea transplants be performed at a Centers of Excellence Facility in order for you to receive Network Benefits. Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.	· Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the CHD service or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up; · Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to **$50** per day for the patient or up to **$100** per day for the patient plus one companion; or · If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to **$100** per day. Travel and lodging expenses are only available if the recipient lives more than **50** miles from the Centers of Excellence Facility (for Transplantation) or the CHD facility. The Company must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include: · Airfare at coach rate; · Taxi or ground transportation; or · Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Centers of Excellence	

	Excellence. A combined overall maximum Benefit of **$10,000** per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures and CHD treatments during the entire period that person is covered under this Plan. **Pre-service Authorization Requirement** For Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Centers of Excellence, Benefits will not be paid.	
The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss. Limited to **1** per calendar year	**80%** of eligible expenses after satisfying the deductible.	**80%** of eligible expenses after satisfying the Network deductible.