UnitedHealthcare®

Benefit Summary
ASO Choice Plus
Greene County Career Center Medical Plan

United HealthCare Services, Inc. and EPC Schools 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		
Individual Deductible Family Deductible	$2,000 per year $4,000 per year	$4,000 per year $8,000 per year
• Member Copayments do not accumulate towards the Deductible unless otherwise notated within the specific benefit category below. • No one in the family is eligible for benefits until the family coverage deductible is met. Deductible carries for 15 months 10-2020 to 12-2021		
Out-of-Pocket Maximum Combined Medical and Pharmacy		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$3,000 per year $6,000 per year	$8,000 per year $16,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	100% 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 policy 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 Deductible has been met	* 100% after Network Deductible has been met
Dental Services – Accident Only		
	100% after Deductible has been met	100% 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. This limit does not apply to wound vacuums.	100% after Deductible has been met	** 80% after Deductible has been met
Emergency Health Services - Outpatient		
	100% after the Deductible has been met and you pay a $200 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 the Deductible has been met and you pay a $200 Copayment per visit.

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
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.	100% after Deductible has been met	80% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	100% after Deductible has been met	* 80% after Deductible has been met
Hospice Care		
	100% after Deductible has been met	* 80% after Deductible has been met
Hospital – Inpatient Stay		
	100% 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.	100% 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		
	100% after Deductible has been met	80% after Deductible has been met
Mental Health Services		
	100% after Deductible has been met 100% after you pay a $60 Copayment per visit	* 80% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	100% after Deductible has been met 100% after you pay a $60 Copayment per visit	* 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.	100% after Deductible has been met	80% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	100% after Deductible has been met	80% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	100% after the Deductible has been met and you pay a $30 Copayment per visit.	* 80% after Deductible has been met
Specialist Physician Office Visit	100% after the Deductible has been met and you pay a $60 Copayment per visit.	* 80% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
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.	100% 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.	
		Prior Authorization is required for certain services.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 60 combined visits of physical therapy, occupational therapy and speech therapy 24 visits of manipulative treatment Unlimited visits of pulmonary rehabilitation Unlimited visits of cardiac rehabilitation Unlimited visits of post-cochlear implant aural therapy Unlimited visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	100% after the Deductible has been met and you pay a $30 Copayment per visit.	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.	100% 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	100% after Deductible has been met	* 80% after Deductible has been met
Substance Use Disorder Services		
	100% after Deductible has been met 100% after you pay a $60 Copayment per visit	* 80% after Deductible has been met
Surgery – Outpatient		
	100% after Deductible has been met	* 80% after Deductible has been met
Transplantation Services		
	* 100% after Deductible has been met	* 80% after Deductible has been met
	For Network Benefits, services must be received at a Designated Facility.	
Urgent Care Center Services		
	100% after the Deductible has been met and you pay a $100 Copayment per visit.	80% after Deductible has been met
Vision Examinations		
Benefits are limited as follows: 1 exam every year	100% after Deductible has been met	Non-Network Benefits are not available

MEDICAL EXCLUSIONS
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.
Alternative Treatments
Acupressure; aromatherapy; hypnotism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.
Dental

Dental care (which includes 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 under the Plan as described in the SPD. 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 are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded,: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Use Disorder

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in the SPD. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; not otherwise excluded in the SPD. Mental Health Services as treatments for R & T code conditions and as treatment for other conditions that may be a focus of clinical attention as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, sexual dysfunction disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilic disorder. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; F for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Intellectual disabilities and Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss, except for temporary loss of hair resulting from treatment of a malignancy.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity.Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective 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). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan
Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. 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.
Transplants
Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).
Travel
Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.
Types of Care
Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
Vision and Hearing
Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy. Routine vision examinations, including refractive examinations to determine the need for vision correction.
All Other Exclusions
Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. 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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. 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. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia.

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Addendum to the Medical Benefit Summary for Self-Funded Groups

Greene County Career Center - Choice Plus

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Gender Dysphoria		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits. *Prior Authorization is required for certain services.*	
This Gender Dysphoria exclusion applies: Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.		
This Procedures and Treatments exclusion no longer applies when Gender Dysphoria applies: Sex transformation operations and related services.		
Mental Health Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*	80% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*	80% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment.
Substance Use Disorder Services		
Partial Hospitalization/Intensive Outpatient Treatment:	100% after Deductible has been met per session for Partial Hospitalization	80% after Deductible has been met per session for Partial Hospitalization

	/Intensive Outpatient Treatment.	/Intensive Outpatient Treatment. *Prior Authorization is required for certain services.*
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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.	100% after Deductible has been met.	Non-Network Benefits are not available.

This replaces the Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders exclusion sections on the Benefit Summary:
Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. [Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders.] Transitional Living services.

This Benefit Summary Addendum is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary Addendum conflicts in any way with the Summary Plan Description (SPF), 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.

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United HealthCare Services, Inc. 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 the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare 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 other 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

UnitedHealthcare®

Medical Benefit Summary Authorization Addendum for Self-Funded Groups Choice Plus

These Prior Authorization requirements shown here will change the Pre-Service Notification requirements indicated on your Benefit Summary.

Network Benefits	Non-Network Benefits
The following benefit requires [Pre-Service Notification][Prior Authorization] for Genetic Testing - BRCA.	
	• Physician's Office Services
The following benefits require [Pre-Service Notification][Prior Authorization] for certain services.	
• Ambulance Services – Non-Emergent Air • Clinical Trials	• Ambulance Services – Non-Emergent Air • [Clinical Trials] • Cochlear Implants] • [Congenital Heart Disease (CHD) Surgeries] • Home Health Care - Nutritional, Private Duty Nursing, Skilled Nursing • Hospice Care- Inpatient Stay • Hospital – Inpatient Stay • [Infertility Services] • Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders-Inpatient [and Outpatient] • Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine • Mental Health and Substance Abuse Services – Outpatient and] Inpatient • Reconstructive Procedures • Skilled Nursing Facility/Inpatient Rehabilitation • Substance Use Disorder Services-Inpatient [and Outpatient]] • Surgery for the treatment for Gender Dysphoria] • Surgery – Outpatient[Sleep Apnea] and Cardiac catheterization, diagnostic cardiac catheterization; cardiac electrophysiology implant, pacemaker insertion, implantable cardioverter defibrillators • Therapeutic Treatments – Outpatient[Dialysis and IV infusion,] [and radiation oncology,] [and intensity modulated radiation therapy,] [and MR-guided focused ultrasound]]
• Transplantation Services	• Transplantation Services
The following benefits require [Pre-Service Notification][Prior Authorization] for Sleep Studies.	
	• Outpatient Diagnostic Services – For lab and radiology/X-ray
The following benefit requires [Pre-Service Notification][Prior Authorization] if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.	
	• Maternity Services
The following benefits require [Pre-Service Notification][Prior Authorization] for Equipment in excess of $1,000.	
	• [Diabetes Services] • Durable Medical Equipment

- Prosthetic Devices

Here's an overview of your CVS Caremark benefits.

Greene Co Career Center HDHP - 1/1/2023

Your annual deductible is $2,000 for an individual or $4,000 for a family. **Until this deductible amount is met, you will pay 100% for your prescriptions**. If you have any questions about your prescription plan or costs, call us at 1-888-202-1654. We can help anytime after your plan starts. For TDD assistance, please call 1-800-863-5488.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	**Long-Term Medicines** CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**$10 after deductible** for a generic medicine	**$25 after deductible** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**$30 after deductible** for a preferred brand-name medicine	**$75 after deductible** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**$50 after deductible** for a non-preferred brand-name medicine	**$125 after deductible** for a non-preferred brand-name medicine
Refill Limit	**None**	**None**
Maximum Out-of-Pocket	**$3,000 per individual / $6,000 per family (combined with medical)**	
Annual Deductible	**$2,000 per individual / $4,000 per family (combined with medical)**	
Specialty Medicines	Specialty medications are required to be filled through CVS Specialty Mail Order Pharmacy or at a retail CVS/pharmacy. Please contact Customer Care toll-free at 1-888-202-1654 for questions or to get started today.	
Prior Authorization	Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-202-1654 or visit www.caremark.com for verification of prior authorization requirements.	

Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654.
If you access your pharmacy benefits information through the Caremark Web site, you can find Plan Members Rights and Responsibilities at www.caremark.com.

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Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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Notice of Nondiscrimination

Federal civil rights laws prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, age, disability, or sex. The laws apply to health programs and activities that receive funding from the Federal government, are administered by a Federal agency or are offered on a public Health Insurance Marketplace. Health plans that are subject to the laws include Medicare Part D plans, Medicaid plans, health plans offered by issuers on Health Insurance Marketplaces, and certain employee health benefit plans. If you have questions about whether these Federal civil rights laws apply to your plan, please contact your health plan at the number in your benefit plan materials.

If your health plan is subject to these Federal civil rights laws, it complies with the laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

- Provides appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us, such as:
  - Auxiliary aids and services
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe these services have not been appropriately provided to you or you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email with your health plan's Civil Rights Coordinator.

You may also contact Customer Care and we will direct your grievance to your health plan's Civil Rights Coordinator:

Nondiscrimination Grievance Coordinator
PO BOX 6590, Lee's Summit, MO 64064-6590
Phone: 1-866-526-4075
TTY: 1-800-863-5488
Fax: 1-855-245-2135
Email: nondiscrimination@cvscaremark.com

If you need additional help filing a grievance, your health plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.