United HealthCare Services, Inc. and Salesforce.com, Inc. 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**

<table>
<thead>
<tr>
<th>Types of Coverage</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Deductible</td>
<td>$1500 per calendar year</td>
<td>$3000 per calendar year</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$3000 per calendar year</td>
<td>$6000 per calendar year</td>
</tr>
</tbody>
</table>

- Member Copayments do not accumulate towards the Deductible unless otherwise noted within the specific benefit category below.
- All covered expenses accumulate toward both the Network and Non-Network deductible.
- Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is no Individual Deductible to satisfy within the Family Deductible.

| Out-of-Pocket Maximum | |
|-----------------------|------------------|----------------------|
| Single Out-of-Pocket Maximum | $3000 per calendar year | $6000 per calendar year |
| Family Out-of-Pocket Maximum | $6000 per calendar year | $12000 per calendar year |

- The Out-of-Pocket Maximum includes the Annual Deductible.
- Coinsurance and Deductibles accumulate toward the Out-of-Pocket Maximum.
- All covered expenses accumulate toward both the Network and Non-Network Out-of-Pocket Maximum.
- Once Family Out-of-Pocket is met, all family members will be considered as having met their Out-of-Pocket for the remainder of the calendar year. There is no Individual Out-of-Pocket to satisfy within the Family Out-of-Pocket.
- Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.

**Benefit Plan Coinsurance – The Amount the Plan Pays**

- 90% after Deductible has been met.
- 70% after Deductible has been met.

**Pharmacy benefits are provided by CVS/Caremark. Please check separate pharmacy documents for benefit details.**

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**Information on Benefit Limits**

- The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.
- Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid.
- When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.
- In order to obtain the highest level of Benefits, you should confirm the Network status of all providers prior to obtaining Covered Health Services.
- Failure to Prior Authorize out of network services will result in $400 penalty only on these services - Inpatient Hospital, Private Duty Nursing, Home Health Care, Hospice Inpatient, SNF / Acute Rehab, Transplant Services.

**BENEFITS**

<table>
<thead>
<tr>
<th>Types of Coverage</th>
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<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Services – Emergency and Non-Emergency</strong></td>
<td>Emergency: 90% after Deductible has been met. Non-Emergency: 90% after Deductible has been met.</td>
<td>Emergency: 90% after Network Deductible has been met. Non-Emergency: 90% after the Deductible has been met.</td>
</tr>
<tr>
<td><strong>Dental Services – Accident Only</strong></td>
<td>90% after Deductible has been met.</td>
<td>90% after Network Deductible has been met.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.</td>
<td></td>
</tr>
<tr>
<td>BENEFITS</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
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</tr>
<tr>
<td><strong>Types of Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Health Services - Inpatient</strong></td>
<td>90% after Deductible has been met.</td>
<td>90% after Deductible has been met.</td>
</tr>
<tr>
<td>If you are admitted as an inpatient to a Network Hospital directly from the Emergency room: the Benefits for an Inpatient Stay in a Network Hospital will apply instead</td>
<td>90% after Deductible has been met.</td>
<td>90% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Benefits are limited as follows: $5000 per calendar year.</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Benefits are limited as follows: 120 visits per year – 1 visit = up to 4 hours</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Hospital – Inpatient Stay</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Lab, X-ray and Diagnostics - Outpatient</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>For Preventive Lab, X-ray and Diagnostics, refer to the Preventive Care Services category.</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Lab, X-ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Neurobiological Disorders - Autism Spectrum Disorders</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Physician’s Office Services – Sickness and Injury</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Primary Physician Office Visit</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Specialist Physician Office Visit</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Pregnancy – Maternity Services</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>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.</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Private Duty Nursing Outpatient</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Limits may apply. Please refer to plan document for more information.</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Covered Health Services include but are not limited to:</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Primary Physician Office Visit</td>
<td>100% Deductible does not apply.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Specialist Physician Office Visit</td>
<td>100% Deductible does not apply.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>Lab, X-ray or other preventive tests</td>
<td>100% Deductible does not apply.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
</tbody>
</table>

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Page 2 of 7
### BENEFITS

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<th>Types of Coverage</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehabilitation Services – Outpatient Therapy and Spinal Manipulative Treatment</strong></td>
<td>Benefits are limited as follows:</td>
<td>Prior Authorization is required for Prosthetic Devices that costs more than $1,000.</td>
</tr>
<tr>
<td>- Physical therapy, Occupational therapy, and Spinal manipulative treatment</td>
<td>90% after Deductible has been met.</td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>- Speech therapy</td>
<td></td>
<td>70% after Deductible has been met.</td>
</tr>
<tr>
<td>- The limits stated above include habilitative services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pulmonary rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cardiac rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Post-cochlear implant aural therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cognitive rehabilitation therapy</td>
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<td></td>
</tr>
</tbody>
</table>

### Skilled Nursing Facility / Inpatient Rehabilitation Facility Services

Benefits are limited as follows: 60 days per calendar year.

90% after Deductible has been met.

70% after Deductible has been met.

### Substance Use Disorder Services

90% after Deductible has been met.

70% after Deductible has been met.

### Surgery – Outpatient

90% after Deductible has been met.

70% after Deductible has been met.

### Transplantation Services

90% after Deductible has been met.

70% after Deductible has been met.

### Urgent Care Services Center

90% after Deductible has been met.

70% after Deductible has been met.

### Virtual Visits

Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider.

90% 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.

### Covered Services

- Acupuncture; acupressure; aromatherapy; hypnosis; massage therapy; rolling (instinctive 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.

### Excluded Services

#### 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extractions (except for partial or full bony impacted wisdom teeth), restoration and replacement of teeth, medical or surgical treatments of dental conditions, 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 – Accident Only in the SPD. Dental implants, bone grafts and other implant related procedures. This exclusion does not apply to accidental-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 when not prescribed by a physician, cranial banding when not deemed medically necessary, 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-esophageal 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 Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit offered by CVS Caremark. 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.

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Experimental or Investigational or Unproven Services

- Services performed in conjunction with experimental procedures or equipment, 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 pharmaceutical 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.

- Vision care treatment of obesity unless there is a diagnosis of morbid obesity.

- Awa

- Blood l

- Ankylosing spondylitis.

- Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and/or deliberate tampering by unpro

- The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and/or deliberate tampering by unpro

- The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and/or deliberate tampering by unpro

- Tubing, nasal oxygen, nebulizers, and masks, 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/or deliberate tampering by unpro

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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


**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 LUÚ Y: Nêu 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 hỏi viện của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 휴대전화번호로 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 русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей
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