UnitedHealthcare®

Benefit Summary

ASO Choice Plus

Commvault Medical Plan Name: Choice Plus Preferred (PPO)

This document is provided as a sample and does not reflect actual benefits. A customized Benefit Summary or Summary Plan Description (SPD) will be created during implementation of the business.

United HealthCare Services, Inc. and Commvault 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.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		
What is an annual deductible? The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible. • Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service. • All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount. • This benefit plan includes a per occurrence deductible that applies to certain covered health care services. This per occurrence deductible must be met prior to and in addition to the medical deductible.		
Medical Deductible – Individual	$500 per year.	$1,000 per year.
Medical Deductible - Family	$1,000 per year.	$2,000 per year.
Out-of-Pocket Limit		
What is an out-of-pocket limit? The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. • Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit – Individual	$3,000 per year.	$6,000 per year.
Out-of-Pocket Limit – Family	$6,000 per year.	$12,000 per year.

Additional Information

What is a co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Ambulance Services			
Emergency Ambulance:	10% co-insurance	Same as Network.	Network: Yes Out-of-Network: Yes
Non-Emergency Ambulance:	10% co-insurance	30% co-insurance.	Network: Yes Out-of-Network: Yes
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.	
Clinical Trials			
	The amount you pay is based on where the covered health care service is provided.		Network: Yes Out-of-Network: Yes
	Prior Authorization is required.	Prior Authorization is required.	
Congenital Heart Disease (CHD) Surgeries			
	Benefits will be the same as stated under Hospital - Inpatient Stay.	Out-of-Network Benefits are not available.	Network: Yes Out-of-Network: Yes
		Prior Authorization is required.	
Dental Services – Accident Only			
	10% co-insurance	Same as Network.	Network: Yes Out-of-Network: Yes
	Prior Authorization is required.	Prior Authorization is required.	
Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.		Network: Yes Out-of-Network: Yes
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider.		
		Prior Authorization is required for DME that costs more than $1,000.	
Durable Medical Equipment (DME), Orthotics and Supplies			
Limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required for DME or orthotics that costs more than $1,000.	
Emergency Health Services - Outpatient			
	$150 co-pay per visit	Same as Network.	Network: No Out-of-Network: No
		Notification is required if confined in an Out-of-Network Hospital.	
Gender Dysphoria			
	The amount you pay is based on where the covered health care service is provided.		Network: Yes Out-of-Network: Yes
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.	

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Habilitative Services			
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.		Deductible will be based on where the covered health care service is provided.
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. – 30 visits per calendar year Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. 20 visits per calendar year	$50 co-pay per visit	30% co-insurance Prior Authorization is required for certain services.	Network: No Out-of-Network: Yes
Hearing Aids			
16 years of age and over: $2500 per ear per 24 months 15 years of age and under - no limit.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Home Health Care			
Limited to 120 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.	10% co-insurance	30% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Hospice Care			
	10% co-insurance	30% co-insurance Prior Authorization is required for Inpatient Stay.	Network: Yes Out-of-Network: Yes
Hospital – Inpatient Stay			
	10% co-insurance	30% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Lab, X-Ray and Diagnostics – Outpatient			
Lab Testing - Outpatient	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
X-Ray and Other Diagnostic Testing - Outpatient	10% co-insurance	30% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Major Diagnostic and Imaging – Outpatient			
	10% co-insurance	30% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Mental Health Care and Substance – Related and Addictive Disorders Services			
Inpatient:	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Outpatient:	$25 copayment per visit	30% co-insurance	Network: No Out-of-Network: Yes
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance	30% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Ostomy Supplies			
	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Pharmaceutical Products- Outpatient			
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Physician Fees for Surgical and Medical Services			
	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Physician's Office Services – Sickness and Injury			
Primary Care Physician Office Visit:	$25 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Specialist Office Visit:	$50 co-pay per visit	30% co-insurance Prior Authorization is required for Genetic Testing.	Network: No Out-of-Network: Yes
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office.			
Pregnancy – Maternity Services			
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.	Deductible will be based on where the covered health care service is provided.
Preventive Care Services			
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing	30% co-insurance	Network: No Out-of-Network: Yes
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.			
Prosthetic Devices			
Limited to every three years, unless needed due to the growth of a	10% co-insurance	30% co-insurance Prior Authorization is required for Prosthetic Devices that costs more than $1,000.	Network: Yes Out-of-Network: Yes

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Reconstructive Procedures			
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.	Deductible will be based on where the covered health care service is provided.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment			
physical therapy occupational therapy Manipulative Treatment 30 visits per calendar year speech therapy pulmonary rehabilitation therapy cardiac rehabilitation therapy 20 visits of post-cochlear implant aural therapy	$50 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Scopic Procedures – Outpatient Diagnostic and Therapeutic			
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services			
Limited to 100 days per year.	10% co-insurance	30% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Surgery – Outpatient			
	10% co-insurance	30% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Therapeutic Treatments – Outpatient			
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance	30% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Transplantation Services			
Network Benefits must be received from a Designated Provider.	10% co-insurance Prior Authorization is required.	30% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Urgent Care Center Services			
	$25 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes

Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Virtual Visits			
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$25 co-pay per visit	Out-of-Network Benefits are not available.	Network: No Out-of-Network: N/A
Acupuncture Services			
	$50 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Infertility Services			
Maximum number of 6 Intrauterine insemination cycles per lifetime. Maximum of 4 complete egg retrievals/lifetime.	Based upon where services are performed. Prior Authorization is required.	30% co-insurance . Prior Authorization is required.	Deductible will be based on where the covered health care service is provided.
Obesity – Weight Loss Surgery			
Limited to 1 surgery per lifetime Limited to COE providers	10% co-insurance Prior Authorization is required.	Not Covered Out of Network . Prior Authorization is required.	Network: Yes
Temporomandibular Joint Services			
.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required for Inpatient Stay.		Deductible will be based on where the covered health care service is provided.
Routine Vision Exam			
1 Exam every 24 months	You pay nothing	30% coinsurance	Network: No Out of network: Yes
Wigs			
Limited $1500 dollars per year as needed for a medical condition	10% co-insurance	30% co-insurance .	Network: Yes Out-of-Network: Yes

This is a list of the services your plan generally does NOT cover. Review your Summary Plan Description (SPD), Schedule of Benefits (SBN) and Riders 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.

- Cosmetic Surgery
- Dental Care
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Weight Loss Programs

UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語**(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی **(Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما چاپ شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध है। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí nínaaltsoos nitł'izí bee nééhozinigii bine'dęę' t'áá jíík'ehgo béésh bee hane'í bilá'igii bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

This Benefit Summary should only be used to highlight your Benefits. Don't use this document to understand your exact coverage, exclusions, and limitations. If this Benefit Summary conflicts with the Summary Plan Description (SPD), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage. This material is provided on the recipient's agreement that it will only be used for the purpose of describing United HealthCare Services, Inc.'s products and services to the recipient. Any other use, copying or distribution without the express written permission of United HealthCare Services, Inc. is prohibited.