State of Florida Employees and Retirees

UnitedHealthcare HMO

Choice plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination[SM] services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

HMO *Benefits Summary*

Types of Coverage	Network Benefits /Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Contract issued to your employer, the Contract shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Annual Deductible:** No Annual Deductible **Out-of-Pocket Maximum:** $1,500 per Covered Person per calendar year, not to exceed $3,000 for all Covered Persons in a family. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Contract Benefit:** No Maximum Policy Benefit.
1. Ambulance Services - Emergency only	Ground Transportation: No Copayment Air Transportation: 0% of Eligible Expenses
2. Autism Spectrum Disorder Services	Covered the same as any other Covered Health Service
3. Dental Services - Accident only	Same as 10, 14, 15 and 16 *Prior notification is required before follow-up treatment begins.
4. Durable Medical Equipment	No Copayment
5. Emergency Health Services	$50 per visit
6. Eye Examinations Refractive eye examinations are limited to one every calendar year from a Network Provider.	$15 per visit
7. Hearing Aids	Same as 4.
8. Home Health Care Benefits are unlimited for skilled care services per calendar year.	No Copayment
9. Hospice Care Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	No Copayment
10. Hospital - Inpatient Stay	$250 per Inpatient Stay
11. Injections Received in a Physician's Office	No copayment applies when a Physician charge is not assessd.
12. Maternity Services	Same as 10, 13, 14 and 15 No Copayment applies to Physician office visits for prenatal care after the first visit. OR No Value if Physician Office is a % copayment *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
13. Neurobiological Disorders	Covered the same as any other Covered Health Service
14. Outpatient Surgery, Diagnostic and Therapeutic Services	
Outpatient Surgery	No Copayment
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	No Copayment
Outpatient Therapeutic Treatments	No Copayment

Types of Coverage	Network Benefits /Copayment Amounts
15. Physician's Office Services	
Covered Health Services for preventive medical care.	$15 per visit for Primary Care; $25 per visit for Specialist No Copayment applies when a Physician charge is not assessed.
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	$15 per visit for Primary Care; $25 per visit for Specialist No Copayment applies when a Physician charge is not assessed.
16. Professional Fees for Surgical and Medical Services	No Copayment
17. Prosthetic Devices	No Copayment
18. Reconstructive Procedures	Same as 10, 14, 15, 16 and 17
19. Rehabilitation Services -Outpatient Therapy Benefits are limited as follows: 60 visits of physical therapy; 60 visits of occupational therapy; 60 visits of speech therapy; 60 visits of pulmonary rehabilitation; and 60 visits of cardiac rehabilitation per calendar year. These limits do not apply to Autism Spectrum Disorder.	$25 per visit
20. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Benefits are limited to 60 days per calendar year.	No Copayment
21. Transplantation Services	Same as 10 and 16
22. Urgent Care Center Services	$25 per visit

Additional Benefits

Bones or Joints of the Jaw and Facial Region	Same as 10, 14, 15 and 16
Child Health Supervision Services	Same as 14, 15 and 16
Cleft Lip/Cleft Palate Treatment	Same as 10, 14, 15, 16 and 19
Dental Procedures - Anesthesia and Hospitalization	Same as 10, 14 and 16
Diabetes Treatment	Same as 4, 14, 15 and 16
Mammography	No Copayment
Mastectomy	Same as 10, 14, 15 and 16
Mental Health and Substance Abuse Services – Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee.	Covered the same as any other outpatient Covered Health Service
Mental Health and Substance Abuse Services – Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee.	Covered the same as any other inpatient Covered Health Service
Osteoporosis Treatment	Same as 14, 15 and 16
Prescription and Non-Prescription Enteral Formulas Benefits for low protein food products for Covered Persons through age 24 are limited to $2,500 per calendar year.	No Copayment
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits are limited to 60 visits per calendar year.	$25 per visit

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Contract, the following are not covered:

A. Alternative Treatments
Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience
Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental
Except as specifically described as covered in Section 1 of the COC under the heading *Dental Services-Accident only* and *Cleft Lip/Cleft Palate Treatment*, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, or gums (including extraction, restoration, and replacement of teeth, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, cleft palate, or dental care described in Section 1 of the COC under the heading. *Dental Procedures - Anesthesia and Hospitalization.* Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly except in connection with cleft lip or cleft palate.

D. Drugs
Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described in Section 1 of the COC under the heading *Diabetes and Treatment.* Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services
Experimental, Investigational or Unproven Services are excluded except (a) bone marrow transplants and (b) medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in the medical literature. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care
Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances
Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes except as described under Section 1 of the COC under the heading *Diabetes Treatment*. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

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

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

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

I. Nutrition
Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups, except as described in Section 1 under the heading *Diabetes Treatment*. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk except as described in Section 1 under the heading *Prescription and Non-prescription Enteral Formulas*.

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

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

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

L. Reproduction
Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan
Health services for which other coverage is paid under arrangements required by federal, state or local law. This includes, but is not limited to, coverage paid by workers' compensation, no-fault automobile insurance, or similar legislation.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

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

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

Transplant services that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel
Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

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

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

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

Health services caused during service in the armed forces of any country.

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

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Contract.

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

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

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature except as described in Section 1 of the COC under the heading *Bones or Joints of the Jaw and Facial Region*.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

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

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cleft lip/cleft palate, Autism Spectrum Disorder or Congenital Anomaly.