Presented by

THE MELTZER GROUP

ABC IMAGING™

BENEFITS GUIDE

Effective Dates | December 1, 2017 – November 30, 2018

Employees

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WELCOME TO YOUR BENEFITS

The benefits offered by ABC Imaging Of Washington, Inc. are designed to provide a comprehensive package for our employees. These benefits are valuable and are provided to assist in managing the health of you and your family.

We encourage you to evaluate and select benefits that best suit the needs for you and your eligible dependents. This benefits guide highlights the many benefit options available to you and explains how to enroll in the benefits you choose. Please read this guide carefully, make your decisions, and enroll.

ELIGIBILITY

All regular, full-time employees are eligible for benefits through ABC Imaging Of Washington, Inc. For benefits purposes only, a regular full-time employee is an employee who is scheduled to work 30 or more hours per week.

Lawful spouses and dependent children may be covered under ABC Imaging Of Washington, Inc. benefits. For a child to be considered a dependent, he or she must be less than 26 years of age regardless of student status. Stepchildren who reside with you, the employee, and who are primarily dependent upon you for support are also considered eligible dependents. Stepchildren are also subject to the age limitations. A child who has a physical or mental disability may be eligible for coverage at any age with proof of disability.

Coverage is effective on the first of month following 30 days of employment. Open enrollment takes place each year. This is the time, other than for a qualifying life event (as listed below), when you can change your benefits elections. During this period, you must determine if you want to make changes to your benefits. If you wish to do so, you must enroll and/or decline coverages for the coming year. **The effective date is December 1st.**

QUALIFYING LIFE EVENTS

- Marriage, legal separation or divorce
- Birth or adoption of a child
- Change in employment status for you or your spouse
- Change in a dependent's benefits eligibility status (i.e. a dependent's child exceeding the maximum age for coverage)
- A significant change in the cost or coverage of your spouse's benefits
- Change in place of residence causing a loss of eligibility (i.e. moving outside of the service area)
- Change in the cost of dependent care (only for the Dependent Care Spending Account)
- Loss of a dependent (death)
- Open enrollment for your spouse

If you qualify for a change in your benefits, please notify ABC Imaging Of Washington, Inc. within 30 days of the change in status. You will need to provide proof of the change.

MEDICAL BENEFITS

UnitedHealthcare

Summary of Service	Optimum Choice HMO Plan AO9S Modified HSA	UnitedHealthcare Choice HMO Plan ASXR Modified HSA	UnitedHealthcare Choice Plus POS Plan ASZJ Modified
Network	**In Network | DC Metro Only**	**In Network**	**In Network**
Annual Deductible	**Single |** $2,500 **Family |** $5,000	**Single |** $2,500 **Family |** $5,000	**Single |** $2,000 **Family |** $4,000
Annual Out-of-Pocket Maximum	**Single |** $3,500 **Family |** $6,850	**Single |** $3,500 **Family |** $6,850	**Single |** $6,350 **Family |** $12,700
Co-Insurance	0%	0%	0%
Office Visits			
Primary Care Physician	Deductible, then No Charge	Deductible, then No Charge	$30 Co-Payment
Specialist	Deductible, then No Charge	Deductible, then No Charge	$30 Co-Payment
Preventive Services	No Charge	No Charge	No Charge
Labs, X-Rays & Diagnostics			
Outpatient Labs	Deductible, then No Charge	Deductible, then No Charge	No Charge
Outpatient X-Rays	Deductible, then No Charge	Deductible, then No Charge	No Charge
Outpatient Diagnostics	Deductible, then No Charge	Deductible, then No Charge	$150 Co-Payment
Hospital Services			
Emergency Room (Waived if Admitted)	Deductible, then $100 Co-Payment	Deductible, then $100 Co-Payment	Deductible, then No Charge
Urgent Care	Deductible, then No Charge	Deductible, then No Charge	$75 Co-Payment
Inpatient Hospitalization	$250 Per Admission	$250 Per Admission	$500 Per Admission
Outpatient Services	Deductible, then No Charge	Deductible, then No Charge	Deductible, then $250 Co-Payment
Prescriptions			
Prescription Deductible	Integrated With Medical	Integrated With Medical	None
Tier 1/ Tier 2 / Tier 3 / Tier 4	$10 / $35 / $60 / N/A	$10 / $35 / $60 / N/A	$10 / $35 / $60 / N/A
Mail Order	2.5 X Retail Co-Payments	2.5 X Retail Co-Payments	2.5 X Retail Co-Payments
Network	**Out-of-Network**	**Out-of-Network**	**Out-of-Network**
Annual Deductible	N/A	N/A	**Single |** $4,000 **Family |** $8,000
Annual Out-of-Pocket Maximum	N/A	N/A	**Single |** $15,000 **Family |** $30,000
Co-Insurance	N/A	N/A	20%
Payroll Contributions			
Employee Only	$109.77	$126.03	$171.96
Employee + Child(ren)	$296.42	$340.32	$425.30
Employee + Spouse	$394.99	$453.52	$559.17
Family	$504.32	$578.99	$707.44

OPTIMUM CHOICE, Inc.
A UnitedHealthcare Company

Benefit Summary

Virginia - Optimum Choice
Optimum Choice HSA - Plan AO9S Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Optimum Choice Plan with an HSA?

Get a plan with a Primary Care Provider (PCP) to help coordinate your care and an HSA to save money.

This is a health plan that requires you to select a PCP who can help guide you through the health care system so you can get the right care at the right time. You can save money when you use the health savings account (HSA) and the network.

> **You need to select your personal PCP from the plan network.** You need to get referrals to see a network specialist. Your PCP must submit all referrals.

> **There's no coverage if you go out-of-network or if you see a network specialist without a referral.** You will be responsible for the entire cost of the service.

> **Preventive care is covered 100% in our network.**

> **You can open a health savings account (HSA).** An HSA is a personal bank account to help you save and pay for your health care, and help you save on taxes.

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-insurance (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
You have no co-insurance	$2,500	You have no co-insurance

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

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

Deductible - Combined Medical and Pharmacy

What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

> No one in the family is eligible for benefits until the family coverage deductible is met.

Medical Deductible - Single Coverage	$2,500 per year
Medical Deductible - Family Coverage	$5,000 per year

Out-of-Pocket Limit - Combined Medical and Pharmacy

What is an out-of-pocket limit?

The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

Out-of-Pocket Limit - Individual	$3,500 per year
Out-of-Pocket Limit - Family	$6,850 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. 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 (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

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.

Common Medical Event	Your cost if you use Network Benefits
Acupuncture Services	
Limited to 12 visits per year.	100%, after the medical deductible has been met.
Ambulance Services	
Emergency	100%, after the medical deductible has been met.
Non-Emergency	100%, after the medical deductible has been met.
Autism Spectrum Disorder Services	
Any limits stated for speech therapy, occupational therapy and/or physical therapy services under Rehabilitation Services-Outpatient Therapy in the Benefit Summary do not apply to Autism Spectrum Disorder Services for Covered Persons two years old through ten years old.	The amount you pay is based on where the covered health service is provided.
Chiropractic Services	
Limited to 20 visits per year.	100%, after the medical deductible has been met.
Clinical Trials	
	The amount you pay is based on where the covered health service is provided.
Congenital Defects and Birth Abnormalities	
	The amount you pay is based on where the covered health service is provided.
Congenital Heart Disease (CHD) Surgeries	
	$250 co-pay per occurrence, after the medical deductible has been met.
Dental Services - Accident Only	
	The amount you pay is based on where the covered health service is provided.
Dental Services - Adjunctive	
	The amount you pay is based on where the covered health service is provided.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Diabetes Services	
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided in the Prescription Drug Rider.
Durable Medical Equipment	
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years or as needed to accommodate growth in young children.	You pay nothing, after the medical deductible has been met.
Early Intervention Services	
	The amount you pay is based on where the covered health service is provided.
Emergency Health Services - Outpatient	
	$100 co-pay, after the medical deductible has been met.
Gender Dysphoria	
	The amount you pay is based on where the covered health service is provided.
Hearing Aids	
Limited to $5,000 per year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Home Health Care	
Limited to 60 visits per year. In accordance with Virginia law and as described in the Certificate of Coverage, Benefits are provided for one home visit for a newborn following obstetrical care in a Hospital and an additional newborn home visit, as prescribed by a Physician. Such visits are not subject to this visit limit.	You pay nothing, after the medical deductible has been met.
Home Treatment of Hemophilia and Congenital Bleeding Disorders	
Benefits for blood infusion equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment.	The amount you pay is based on where the covered health service is provided.
Hospice Care	
	You pay nothing, after the medical deductible has been met.
Hospital - Inpatient Stay	
	$250 co-pay per occurrence, after the medical deductible has been met.
Infertility Services	
Limited to a maximum of six cycles of artificial insemination per Covered Person during the entire period of time she is enrolled for coverage under the Policy.	You pay nothing, after the medical deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient	
	You pay nothing, after the medical deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Mental Health Services	
Inpatient:	$250 co-pay, after the medical deductible has been met.
Outpatient:	You pay nothing, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	$250 co-pay, after the medical deductible has been met.
Neurobiological Disorders – Autism Spectrum Disorder Services	
Inpatient:	$250 co-pay, after the medical deductible has been met.
Outpatient:	10% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	$250 co-pay, after the medical deductible has been met.
Ostomy and Urologic Supplies	
	You pay nothing, after the medical deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services	
	You pay nothing, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury	
Primary Care Physician Office Visit	You pay nothing, after the medical deductible has been met.
Specialist Physician Office Visit	You pay nothing, after the medical deductible has been met.
Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health service is provided.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Preventive Care Services	
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.
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 a single purchase of each type of prosthetic device every 3 years.	You pay nothing, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health service is provided.
Rehabilitation and Habilitative Services	
Limited to: 60 visits of physical therapy, occupational therapy, and speech therapy combined. 20 visits of outpatient pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. Note: Rehabilitation Services in connection with the Early Intervention Services Benefit are not subject to the limits stated above.	The amount you pay is based on where the covered health service is provided.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 60 days per year.	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Substance Use Disorder Services	
Inpatient:	$250 co-pay, after the medical deductible has been met.
Outpatient:	You pay nothing, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	$250 co-pay, after the medical deductible has been met.
Surgery - Outpatient	
	You pay nothing, after the medical deductible has been met.
Temporomandibular Disorder Services	
	The amount you pay is based on where the covered health service is provided.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.
Transplantation Services	
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided.
Urgent Care Center Services	
	You pay nothing, after the medical deductible has been met.
Virtual Visits	
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.	You pay nothing, after the medical deductible has been met.

OPTIMUM CHOICE, Inc.
A UnitedHealthcare Company

Benefit Summary

Outpatient Prescription Drug

Virginia
10/35/60Plan 2V

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Deductible	
Individual Deductible	See Medical Benefit Summary
Family Deductible	See Medical Benefit Summary
Out-of-Pocket Limit	
Individual Out-of-Pocket Limit	See Medical Benefit Summary
Family Out-of-Pocket Limit	See Medical Benefit Summary

A deductible and out-of-pocket limit may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket limit amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your co-payment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the co-payments outlined below. If you reach the out-of-pocket limit, you will not be required to pay a co-payment.

Tier Level	**Retail** Up to 31-day supply	***Mail Order** Up to 90-day supply
	Network	**Network**
Tier 1	**$10**	**$25**
Tier 2	**$35**	**$87.50**
Tier 3	**$60**	**$150**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

UnitedHealthcare®

Benefit Summary

Virginia - Choice
HSA - Plan ASXR Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plan with an HSA?

Use our national network and an HSA to save money.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network. You can save money when you use the health savings account (HSA) and the network.

> **Save money by staying in our network.** If you don't use the network, you'll have to pay for all of the costs.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

> **You can open a health savings account (HSA).** An HSA is a personal bank account to help you save and pay for your health care, and help you save on taxes.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choicehsa** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
You have no co-payment.	$2,500	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

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
Deductible - Combined Medical and Pharmacy	

What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

> No one in the family is eligible for benefits until the family coverage deductible is met.

Medical Deductible - Single Coverage	$2,500 per year
Medical Deductible - Family Coverage	$5,000 per year

Out-of-Pocket Limit - Combined Medical and Pharmacy

What is an out-of-pocket limit?

The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

Out-of-Pocket Limit - Individual	$3,500 per year
Out-of-Pocket Limit - Family	$6,850 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. 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 (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

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.

Common Medical Event	Your cost if you use Network Benefits
Ambulance Services	
Emergency	You pay nothing, after the medical deductible has been met.
Non-Emergency	You pay nothing, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder Services	
Any limits stated for speech therapy, occupational therapy and/or physical therapy services under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder Services for Covered Persons two years old through ten years old.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required for certain services.
Cleft Lip and Cleft Palate Treatment	
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required for certain services.
Clinical Trials	
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Congenital Defects and Birth Abnormalities	
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required for certain services.
Congenital Heart Disease (CHD) Surgeries	
	$250 co-pay per Admit, after the medical deductible has been met.
Dental Anesthesia and Facility Services	
	The amount you pay is based on where the covered health service is provided.
Dental Services - Accident Only	
	You pay nothing, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Diabetes Services	
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.
Diabetes Self Management Items:	Benefits for diabetes supplies will be the same as those stated in the Outpatient Prescription Drug Rider. For insulin pumps, you pay nothing, after the medical deductible has been met.
Durable Medical Equipment	
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	You pay nothing, after the medical deductible has been met.
Early Intervention Services	
	The amount you pay is based on where the covered health service is provided.
Emergency Health Services - Outpatient	
	$100 co-pay, after the medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.
Gender Dysphoria	
	The amount you pay is based on where the covered health service is provided.
Hearing Aids	
Limited to $5,000 per year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.
Home Health Care	
Limited to 60 visits per year. In accordance with Virginia law, Benefits are provided for home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital. Such visits are not subject to the above annual maximums.	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Home Treatment of Hemophilia and Congenital Bleeding Disorders	
Benefits for blood infusion equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment.	The amount you pay is based on where the covered health service is provided for blood infusion equipment and blood products, and will be the same as those stated under Durable Medical Equipment, Pharmaceutical Products - Outpatient, or in the Outpatient Prescription Drug Rider.
Hospice Care	
	You pay nothing, after the medical deductible has been met.
Hospital - Inpatient Stay	
	$250 co-pay per admit, after the medical deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient	
	You pay nothing, after the medical deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	You pay nothing, after the medical deductible has been met.
Mental Health Services	
Inpatient:	$250 co-pay per admit, after the medical deductible has been met.
Outpatient:	You pay nothing, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.
Neurobiological Disorders – Autism Spectrum Disorder Services	
Inpatient:	$250 co-pay per admit, after the medical deductible has been met.
Outpatient:	You pay nothing, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.
Ostomy Supplies	
	You pay nothing, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services	
	You pay nothing, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury	
Primary Physician Office Visit	You pay nothing, after the medical deductible has been met.
Specialist Physician Office Visit	You pay nothing, after the medical deductible has been met.
Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health service is provided.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.
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 a single purchase of each type of prosthetic device every 3 years.	You pay nothing, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health service is provided.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment	
Limited to: 20 visits of pulmonary rehabilitation. 36 visits of cardiac rehabilitation. 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of manipulative treatments. Note: Rehabilitation Services - Outpatient Therapy in connection with the Early Intervention Services Benefit are not subject to annual visit limits stated above.	You pay nothing, after the medical deductible has been met.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 60 days per year.	$250 co-pay per admit, after the medical deductible has been met.
Substance Use Disorder Services	
Inpatient:	$250 co-pay per admit, after the medical deductible has been met.
Outpatient:	You pay nothing, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.
Surgery - Outpatient	
	You pay nothing, after the medical deductible has been met.
Temporomandibular Joint Services	
	The amount you pay is based on where the covered health service is provided.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.
Transplantation Services	
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
Urgent Care Center Services	
	You pay nothing, after the medical deductible has been met.
Virtual Visits	
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.	You pay nothing, after the medical deductible has been met.

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Virginia

10/35/60 Plan 2V

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Deductible	
Individual Deductible	See Medical Benefit Summary
Family Deductible	See Medical Benefit Summary
Out-of-Pocket Limit	
Individual Out-of-Pocket Limit	See Medical Benefit Summary
Family Out-of-Pocket Limit	See Medical Benefit Summary

A deductible and out-of-pocket limit may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket limit amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your co-payment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the co-payments outlined below. If you reach the out-of-pocket limit, you will not be required to pay a co-payment.

Benefit Plan Co-payment/Co-insurance - The amount you pay.

Tier Level	Retail Up to 31-day supply	*Mail Order Up to 90-day supply
	Network	**Network**
Tier 1	**$10**	**$25**
Tier 2	**$35**	**$87.50**
Tier 3	**$60**	**$150**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

UnitedHealthcare®

Benefit Summary

Virginia - Choice Plus
Balanced 100 - Plan ASZJ Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$30	$2,000	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

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
Deductible		
What is a deductible?		
The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all 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 common medical event.		
> 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 common medical events. This per occurrence deductible must be met prior to and in addition to the medical deductible.		
Medical Deductible - Individual	$2,000 per year	$4,000 per year
Medical Deductible - Family	$4,000 per year	$8,000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$6,350 per year	$15,000 per year
Out-of-Pocket Limit - Family	$12,700 per year	$30,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. 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 (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

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.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services		
Emergency	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
Non-Emergency	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorder Services		
Any limits stated for speech therapy, occupational therapy and/or physical therapy services under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in this Benefit Summary do not apply to Autism Spectrum Disorder Services for Covered Persons two years old through ten years old.	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Cleft Lip and Cleft Palate Treatment		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Defects and Birth Abnormalities		
	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.
Congenital Heart Disease (CHD) Surgeries		
	You pay nothing after you pay the $500 per occurrence deductible per Inpatient Stay and the medical deductible has been met.	20% co-insurance, after you pay the $500 per occurrence deductible per Inpatient Stay and the medical deductible has been met.
		Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Anesthesia and Facility Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required.
Dental Services - Accident Only		
	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
Diabetes Self Management Items:	Benefits for diabetes supplies will be the same as those stated in the Outpatient Prescription Drug Rider.	Benefits for diabetes supplies will be the same as those stated in the Outpatient Prescription Drug Rider.
	For insulin pumps, you pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Early Intervention Services		
	The amount you pay is based on where the covered health service is provided.	
Emergency Health Services - Outpatient		
	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met .
		Notification is required if confined in an Out-of-Network Hospital.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Gender Dysphoria		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required for certain services.
Hearing Aids		
Limited to $5,000 per year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 visits per year. In accordance with Virginia law, Benefits are provided for home visit or visits for the mother as part of postpartum care following obstetrical care in a Hospital. Such visits are not subject to the above annual maximums.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Home Treatment of Hemophilia and Congenital Bleeding Disorders		
Benefits for blood infusion equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment.	The amount you pay is based on where the covered health service is provided for blood infusion equipment and blood products, and will be the same as those stated under Durable Medical Equipment, Pharmaceutical Products - Outpatient, or in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Hospice Care		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	You pay nothing after you pay the $500 per occurrence deductible per Inpatient Stay and the medical deductible has been met.	20% co-insurance after you pay the $500 per occurrence deductible per Inpatient Stay and the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing. A deductible does not apply.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	$150 co-pay per service. A deductible does not apply.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Mental Health Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	$30 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	$30 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health 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.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
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 a single purchase of each type of prosthetic device every 3 years.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of pulmonary rehabilitation. 36 visits of cardiac rehabilitation. 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of manipulative treatments. Note: Rehabilitation Services - Outpatient Therapy in connection with the Early Intervention Services Benefit are not subject to annual visit limits stated above.	$30 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Substance Use Disorder Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient:	$30 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Surgery - Outpatient		
	You pay nothing after you pay the $250 per occurrence deductible per date of service and the medical deductible has been met.	20% co-insurance after you pay the $250 per occurrence deductible per date of service and , after the medical deductible has been met.
		Prior Authorization is required for certain services.
Temporomandibular Joint Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$75 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
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.	$25 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Virginia
10/35/60 Plan 2V

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Non-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network	
Individual Out-of-Pocket Limit	See Medical Benefit Summary
Family Out-of-Pocket Limit	See Medical Benefit Summary

Out-of-Pocket Limit does not apply Non-Network and Coupons.

Benefit Plan Co-payment/Co-insurance - The amount you pay.

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 2	**$35**	**$35**	**$87.50**
Tier 3	**$60**	**$60**	**$150**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

New 2018 guidelines for Health Savings Account (HSA)

Please see updated guidelines for 2018.

	2018 Guidelines		2017 Guidelines	
Minimum deductible amounts	$1,350 self only plans $2,700 for family plans /$2,700 for embedded individual deductible family plans.		$1,300 self only plans $2,600 for family plans /$2,600 for embedded individual deductible family plans.	
Maximum out-of-pocket limits	$6,650 for individual / self-only plans	$13,300 for family plans Note: Changes due to ACA, a non-embedded family OOPM cannot be greater than $7,350 (2018).	$6,550 for individual / self only plans	$13,100 for family plans. Note: Changes due to ACA, a non-embedded family OOPM cannot be greater than $7,150 (2017).
HSA contribution limits	Consumers can contribute up to the annual maximum amount as determined by the IRS. Maximum contribution amounts for 2018 are $3,450 for self only and $6,900 for families.		Consumers can contribute up to the annual maximum amount as determined by the IRS. Maximum contribution amounts for 2017 are $3,400 for self only and $6,750 for families.	
Prorating of contribution limits	Enrolled by Dec. 1 and stay enrolled for the 13-month test period. OR Proration applies which means dividing the contribution limit by 12 and contribute that amount each month you are enrolled in a HDHP.		Enrolled by Dec. 1 and stay enrolled for the 13-month test period. OR Proration applies which means dividing the contribution limit by 12 and contribute that amount each month you are enrolled in a HDHP.	
IRA to HSA transfer	Consumers are able to make a one-time, tax-free trustee-to-trustee transfer of IRA funds into an HSA. The individual must remain enrolled in high-deductible health plan and eligible for an HSA for a 13-month test period after the fund transfer. The funds transferred from the IRA apply to the annual HSA maximum contribution limit. The contribution must be made directly by the IRA trustee.		Consumers are able to make a one-time, tax-free trustee-to-trustee transfer of IRA funds into an HSA. The individual must remain enrolled in high-deductible health plan and eligible for an HSA for a 13-month test period after the fund transfer. The funds transferred from the IRA apply to the annual HSA maximum contribution limit. The contribution must be made directly by the IRA trustee.	
FSA 2 1/2 month grace period	Only Limited Purpose Flexible Spending Account may be offered alongside the HSA without impacting a member's eligibility for HSA contributions. Consumers in a full purpose FSA can contribute to an HSA if their FSA balance is zero at the end of the preceding year.		Only Limited Purpose Flexible Spending Account may be offered alongside the HSA without impacting a member's eligibility for HSA contributions. Consumers in a full purpose FSA can contribute to an HSA if their FSA balance is zero at the end of the preceding year.	
Comparable contributions	Employers may under certain conditions be eligible to make higher contributions for "non-highly compensated employees" without a cafeteria plan. Employer contributions to an HSA based on completion of wellness activities would still require funding through a cafeteria plan.		Employers may under certain conditions be eligible to make higher contributions for "non-highly compensated employees" without a cafeteria plan. Employer contributions to an HSA based on completion of wellness activities would still require funding through a cafeteria plan.	

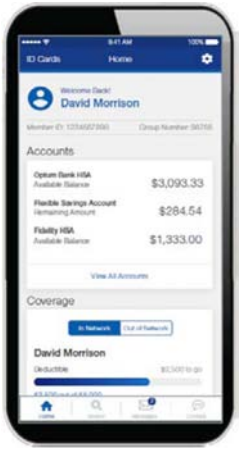
The UnitedHealthcare plan with Health Savings Account (HSA) is a high deductible health plan (HDHP) that is designed to comply with IRS requirements so eligible enrollees may open a Health Savings Account (HSA) with a bank of their choice or through Optum Bank, Member of FDIC. The HSA refers only and specifically to the Health Savings Account that is provided in conjunction with a particular bank, such as Optum Bank, and not to the associated HDHP. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Services, Inc. or their affiliates. Health savings accounts (HSAs) are individual accounts offered by Optum Bank, Member FDIC, and are subject to eligibility and restrictions, including but not limited to restrictions on distributions for qualified medical expenses set forth in section 213(d) of the Internal Revenue Code. This communication is not intended as legal or tax advice. Please contact a competent legal or tax professional for personal advice on eligibility, tax treatment, and restrictions. Federal and state laws and regulations are subject to change.

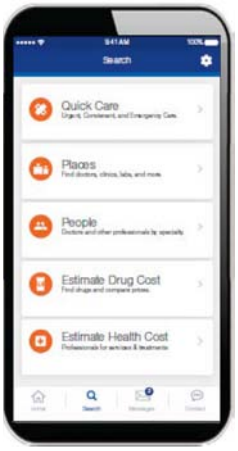
UnitedHealthcare®

UnitedHealthcare Health4Me® features overview.

Users have access to:

- A member interface that is consistent with the new myuhc.com®.
- "Contact Us" for quick access to customer service.
- HealthSafe ID™ to protect member information and allow access to all HSID sites using the same log-in.





Home screen

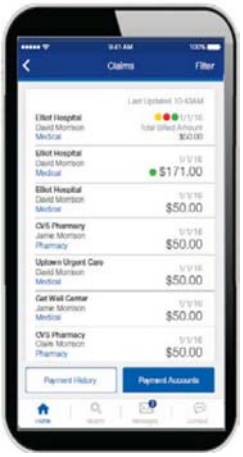
- View or print health plan **ID cards**.
- See **account balances**.
- Get current **coverage information**.
- An intuitive, scrolling design displays **key information**.

Search screen

- Locate **physicians** and **facilities**.
- Learn about **procedures** and **treatments**.
- Research available **providers**.
- Review **hospital quality** and **safety data**.
- Provides price and quality for over **875 medical services** across nearly **600 health events**.
- Compare **costs**.

UnitedHealthcare®

UnitedHealthcare Health4Me features overview.

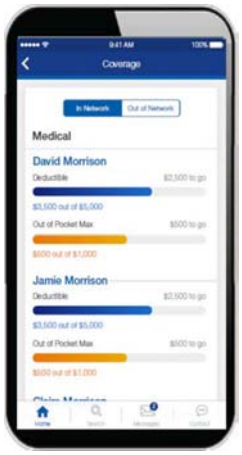


Claims

- Find out how each claim was **processed** and **paid**.
- Pay claims **online**.
- Add **notes** on claims to watch.
- Filter by **claim type**, **family member** or **payment status** and see claim **details**.

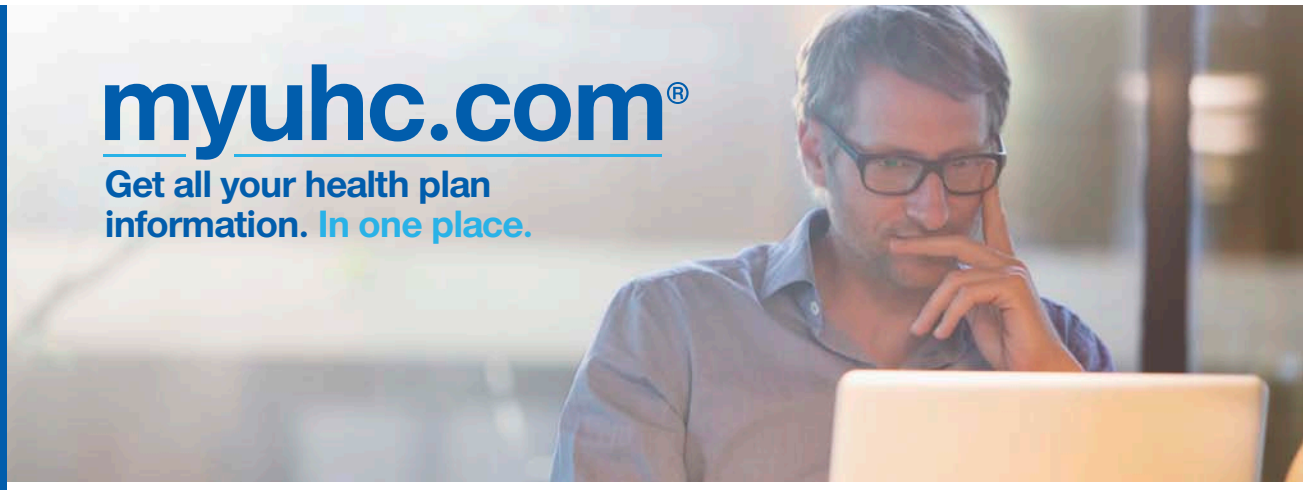
Medicine cabinet

- Keep track of the **prescription drugs** being taken, by subscribers and dependents.
- Makes it easier to **order refills** by mail.
- Research **lower-cost pharmacy options** (OptumRx).



Coverage

- See how much of the **deductible** has been met.
- View the **out-of-pocket maximum**.
- **Information** available for subscriber and dependents.



myuhc.com®

Get all your health plan information. In one place.

Make informed decisions.

As a member, **myuhc.com** gives you personalized plan information, care choices, budgeting tools and wellness tips – all in one spot. Download the UnitedHealthcare Health4Me® mobile app for on-the-go access.

Find and price the care you need.

The find-and-price care tool makes it simple to find a doctor, clinic, hospital, or lab based on location, specialty, reputation, cost of services, availability or hours of operation. You can even see patient ratings and compare quality and costs before you choose services.

Know your health care costs.

Get a clear picture of spending. View a snapshot of account activity, benefits received and outstanding balances.

Track claims. Easily see the status of your claims.

Get and stay healthy.

Discover wellness tools and advice. Tailored to help you live healthier, and get the most from your plan.

Achieve your health goals. Set goals and reach them with individualized recommendations on exercise, diet, therapy and more.

Join a healthy-living community. Connect with other members for support and to share ideas on how to live balanced, healthy and active lives.

Experience the plan that connects with you.

- **myuhc.com** places your plan information at your fingertips.
- The **Health4Me** mobile app provides on-the-go access.
- **Expert support** is here when you have questions.
  - **Ask a Nurse.** 24/7 phone access to a registered nurse.
  - **Chat online.** Rapid replies and guidance through **myuhc.com**.
  - **Talk with us.** Request that a plan representative call you.

Join the millions of UnitedHealthcare members discovering faster, easier and better ways to connect to their health plan.

UnitedHealthcare®

FREE!*

Real people.
Real Appeal.

Everything you need to lose weight and keep it off — FREE to eligible UnitedHealthcare® members.*

Join today at success.realappeal.com.

Dave L.
Age 47

"I'm stronger. I have a lot more energy. Thank you, Real Appeal."

Tashawna O.
Age 37

"This is no diet — this is not a gimmick. I feel great!"

UnitedHealthcare®

Thank you for being a UnitedHealthcare member. We are excited to offer Real Appeal, a free digital program that provides you with up to a full year of support for lasting weight loss.* **On average, participants lose 10 pounds after attending just 4 online classes.** Your program includes:

Personal transformation coach

- Step-by-step guidance and customization for a program that fits your needs, preferences and goals.
- Support and motivation for a full year to help you lose weight or maintain results.
- A personalized dashboard to keep track of your calories, fitness and goals.

24/7 convenience

Staying accountable to your goals is easier than ever with:

- Food, activity, weight and goal trackers.
- Unlimited access to digital content.
- Your online group class, which is designed to help you build camaraderie and accountability with others in the program.
- Weekly health tips from celebrities, athletes and health experts.

Success kit

Resources to help you kick-start your weight loss and keep yourself on the road to results. Your kit will be delivered after your first class. It includes:

- Step-by-step Success Guides.
- Workout DVDs.
- Quick and simple recipes.
- Nutrition guide.
- And much more.

Join the thousands of members that have lost nearly 1 million pounds. Start today at **success.realappeal.com.** Spark your transformation with Real Appeal.

*The Real Appeal program is provided to eligible members at no additional cost to you as part of your benefit plan.

Real Appeal is a voluntary weight loss program that is offered to eligible participants over age 18 as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Real Appeal

UnitedHealthcare®

Tools
Virtual Visits

See a doctor whenever, wherever. Virtual Visits

Get access to care 24/7 with Virtual Visits. A Virtual Visit lets you see a doctor from your mobile device or computer without an appointment.

Choose from an AmWell or Doctor on Demand network provider and pay $40 or less for the visit.

AmWell app

Doctor On Demand app*

To learn more and start a visit, go to **uhc.com/virtualvisits** or the UnitedHealthcare Health4Me® app. You can also go directly to **amwell.com** or **doctorondemand.com**—or the AmWell or Doctor On Demand mobile apps.

Virtual Visits are covered under your health plan benefits either way you decide to access care.

Tips for registering:

1. Locate your member ID number on your health plan ID card.
2. Have your credit card ready to cover any costs not covered by your health plan.
3. Choose a pharmacy that's open in case you're given a prescription.**

To learn more about Virtual Visits,
go to **uhc.com/virtualvisits** or **myuhc.com**.

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*Doctor On Demand does not support any version of Internet Explorer®.

**Prescription services may not be available in all states.

DENTAL BENEFITS

UnitedHealthcare

UnitedHealthcare Insurance Company (30100)®				Dental Plan
Voluntary Options PPO 20 / covered dental services				New Standard/0P646/MAC
	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$1,500 per person per Calendar Year	$1,500 per person per Calendar Year	$1,000 per person per Lifetime	$1,000 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Child Only (Up to Age 19)	
CMM-Annual Roll-Over			Yes	
COVERED SERVICES *	**NETWORK PLAN PAYS****	**NON-NETWORK PLAN PAYS*****	**BENEFIT GUIDELINES**	
DIAGNOSTIC SERVICES				
Periodic Oral Evaluation	100%	50%	See Exclusions and Limitations section for benefit guidelines.	
Radiographs	100%	50%		
Lab and Other Diagnostic Tests	100%	50%		
PREVENTIVE SERVICES				
Prophylaxis (Cleaning)	100%	50%	See Exclusions and Limitations section for benefit guidelines.	
Fluoride Treatment (Preventive)	100%	50%		
Sealants	100%	50%		
Space Maintainers	100%	50%		
BASIC SERVICES				
Restorations (Amalgams or Composite)	80%	30%	See Exclusions and Limitations section for benefit guidelines.	
Emergency Treatment/General Services	80%	30%		
Simple Extractions	80%	30%		
Oral Surgery (incl. surgical extractions)	80%	30%		
Periodontics	80%	30%		
Endodontics	80%	30%		
MAJOR SERVICES				
Inlays/Onlays/Crowns	50%	25%	See Exclusions and Limitations section for benefit guidelines.	
Dentures and Removable Prosthetics	50%	25%		
Fixed Partial Dentures (Bridges)	50%	25%		
Implants	50%	25%		
ORTHODONTIC SERVICES				
Diagnose or correct misalignment of the teeth or bite	50%	50%		

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.
***The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.
In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment, and

D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

5 DENTAL PROPHLYAXIS Limited to 2 times per consecutive 12 months.

6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.

10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

11 INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

13 POST AND CORES Covered only for teeth that have had root canal therapy.

14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

25 GENERAL ANESTHESIA Covered only when clinically necessary.

26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

The following are not covered:

1 Dental Services that are not Necessary.

2 Hospitalization or other facility charges.

3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

5 Any Dental Procedure not directly associated with dental disease.

6 Any Dental Procedure not performed in a dental setting.

7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. 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 Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

8 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

9 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

10 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

11 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

12 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

13 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

14 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

15 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

16 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

17 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

18 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

19 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

20 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups sitused in the state of Arizona, in order to comply with state regulations.

21 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

22 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

23 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

24 Foreign Services are not Covered unless required as an Emergency.

25 Dental 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.

26 Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

UnitedHealthcare Insurance Company (30100)® Dental Plan
Voluntary Options PPO 20 / covered dental services New Standard/0P689/MAC

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$1,500 per person per Calendar Year	$1,500 per person per Calendar Year	$1,000 per person per Lifetime	$1,000 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Child Only (Up to Age 19)	
CMM-Annual Roll-Over			Yes	

COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	100%	
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (Preventive)	100%	100%	
Sealants	100%	100%	
Space Maintainers	100%	100%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	80%	80%	
Simple Extractions	80%	80%	
Oral Surgery (incl. surgical extractions)	80%	80%	
Periodontics	80%	80%	
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	See Exclusions and Limitations section for benefit guidelines.
Dentures and Removable Prosthetics	50%	50%	
Fixed Partial Dentures (Bridges)	50%	50%	
Implants	50%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

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27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

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5 Any Dental Procedure not directly associated with dental disease.

6 Any Dental Procedure not performed in a dental setting.

7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. 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 Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

8 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

9 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

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13 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

14 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

15 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

16 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

17 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

18 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

19 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

20 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups sitused in the state of Arizona, in order to comply with state regulations.

21 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

22 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

23 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

24 Foreign Services are not Covered unless required as an Emergency.

25 Dental 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.

26 Services for injuries or conditions covered by Worker’s Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

UnitedHealthcare Insurance Company (30100)® Dental Plan
Voluntary Options PPO 30 / covered dental services New Standard/4P763/U80

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$1,500 per person per Calendar Year	$1,500 per person per Calendar Year	$2,000 per person per Lifetime	$2,000 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Child Only (Up to Age 19)	
CMM-Annual Roll-Over			Yes	

COVERED SERVICES *	**NETWORK PLAN PAYS****	**NON-NETWORK PLAN PAYS*****	**BENEFIT GUIDELINES**
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	100%	
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (Preventive)	100%	100%	
Sealants	100%	100%	
Space Maintainers	100%	100%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	80%	80%	
Simple Extractions	80%	80%	
Oral Surgery (incl. surgical extractions)	80%	80%	
Periodontics	80%	80%	
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	See Exclusions and Limitations section for benefit guidelines.
Dentures and Removable Prosthetics	50%	50%	
Fixed Partial Dentures (Bridges)	50%	50%	
Implants	50%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.
***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment, and

D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

5 DENTAL PROPHLYAXIS Limited to 2 times per consecutive 12 months.

6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.

10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

11 INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

13 POST AND CORES Covered only for teeth that have had root canal therapy.

14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

25 GENERAL ANESTHESIA Covered only when clinically necessary.

26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

The following are not covered:

1 Dental Services that are not Necessary.

2 Hospitalization or other facility charges.

3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

5 Any Dental Procedure not directly associated with dental disease.

6 Any Dental Procedure not performed in a dental setting.

7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. 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 Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

8 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

9 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

10 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

11 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

12 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

13 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

14 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

15 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

16 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

17 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

18 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

19 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

20 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups sitused in the state of Arizona, in order to comply with state regulations.

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24 Foreign Services are not Covered unless required as an Emergency.

25 Dental 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.

26 Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

VISION BENEFITS

UnitedHealthcare

ABC Imaging of Washington DC

Benefit Plan Year 12/01/2016 - 11/30/2019

UnitedHealthcare®

Vision Benefit Summary

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating[1] and the frame, or contact lenses in lieu of eyeglasses.

	Exam Only	Exam with Materials
Benefit Frequency		
Comprehensive Exam(s)	Once every 12 months	Once every 12 months
Spectacle Lenses	N/A	Once every 24 months
Frames	N/A	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	N/A	Once every 24 months
In-Network Services		
Copays		
Exam(s)	$ 15.00	$ 15.00
Materials	N/A	$ 20.00
Frame Benefit (applies to Exam and Materials Benefit only) For frames that exceed the allowance, an additional 30% discount may be applied to the overage[2]		
Private Practice Provider	N/A	$130.00 retail frame allowance
Retail Chain Provider	N/A	$130.00 retail frame allowance
Lens Options		
The Exam and Materials Benefit includes Standard Scratch-resistant Coating,Polycarbonate Lenses for Dependents covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider).		
Contact Lens Benefit[3] (applies to Exam and Materials Benefit only) Selection contact lenses refer to formulary contact list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at myuhcvision.com.		
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable). If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider.		
Non-selection contact lenses A $130.00 allowance is applied toward the purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.		
Necessary contact lenses[4] Covered in full after applicable copay.		
Out-of-Network Reimbursements (Copays do not apply)		
Exam(s)	Up to $ 40.00	Up to $40.00
Frames	N/A	Up to $45.00
Single Vision Lenses	N/A	Up to $40.00
Lined Bifocal Lenses	N/A	Up to $60.00
Lined Trifocal Lenses	N/A	Up to $80.00
Lenticular Lenses	N/A	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[3]	N/A	Up to $130.00
Necessary Contacts in Lieu of Eyeglasses[4]	N/A	Up to $210.00

Discounts	
	Laser vision UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik*Plus*® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.
	Additional Material (applies to Exam and Materials Benefit only) At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.

[1]On all orders processed through a company owned and contracted lab network.
[2]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[3]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
[4] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your $130.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers.

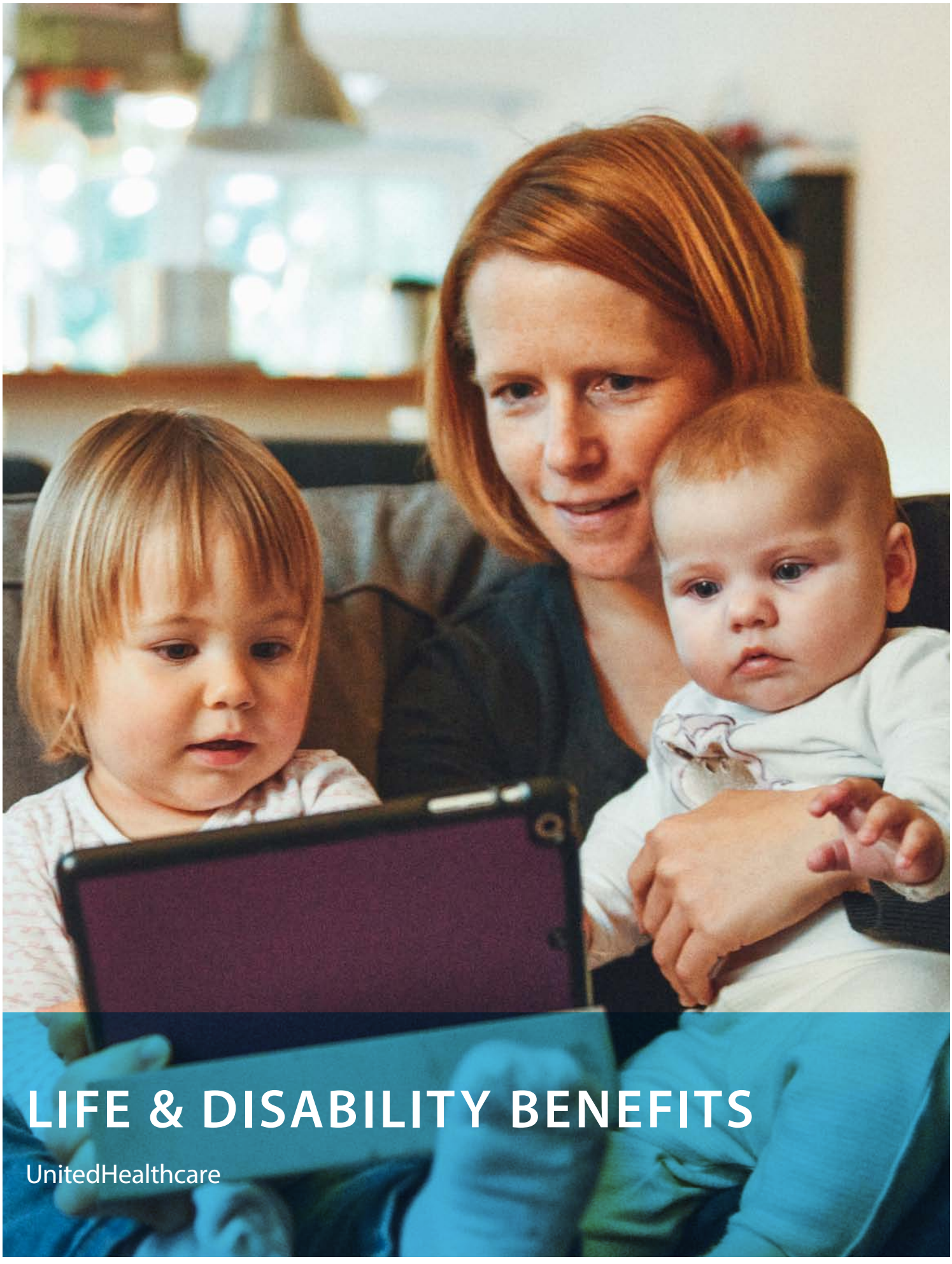
Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

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 healthcare 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 Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.



LIFE & DISABILITY BENEFITS

UnitedHealthcare

Basic Life and AD&D Insurance
Supplemental Life and AD&D Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

Am I eligible?	You are eligible if you are an All Other Active, Full-Time Employee excluding Directors and Texas Employees who works at least 30 hours per week on a regularly scheduled basis.
How much company paid Basic Life and AD&D do I have?	Your employer provides, at no cost to you, Employee Basic Life and AD&D Insurance in the amount of $25,000.
How much Employee Supplemental Life and AD&D can I purchase?	You can purchase Supplemental Life and AD&D Insurance in increments of $10,000, $10,000 minimum to a $500,000 maximum. However, coverage cannot exceed 5 times your Annual Earnings. Annual Earnings are defined in UnitedHealthcare's contract with your employer.
How much Spouse Supplemental Life and AD&D can I purchase?	If you elect Employee Supplemental Life and AD&D Insurance for yourself, you may choose to purchase Spouse Supplemental Life and AD&D Insurance in increments of $5,000, $5,000 minimum to a maximum of $250,000. However, coverage cannot exceed 50% of the employee's Supplemental Life and AD&D amount. You may not elect coverage for your Spouse if they are already covered as an Employee under this policy.
How much Child(ren) Supplemental Life and AD&D can I purchase?	If you elect Supplemental Life and AD&D Insurance for yourself, you may choose to purchase Child(ren)* Supplemental Life and AD&D Insurance for child(ren) 6 months and Over in the amounts of $1,000, $2,000, $4,000, $5,000 or $10,000. However, coverage cannot exceed 50% of the employee's Supplemental Life and AD&D amount. Paid benefit is limited to $500 for a child age 14 days to 6 months. No benefit is paid for a child under 14 days old. **Eligible Child(ren) are from 14 days to age 26.*
What is the highest amount of Supplemental Life I can buy without filling out a medical questionnaire? (Guarantee Issue Limit)	**New Hire, First Time Eligible:** **Employee-** You may elect up to $100,000. Amounts greater will require evidence of good health/insurability. **Spouse-** You may elect up to $30,000. Amounts greater will require evidence of good health/insurability. **Child(ren)-** You may elect up to $10,000. **Late Entrant (did not enroll within 31 days of eligibility):** For Employee and Spouse coverage, evidence of good health/insurability is required for any requested amount.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

UnitedHealthcare®

Basic Life and AD&D Insurance
Supplemental Life and AD&D Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

What does Basic AD&D provide me?	Accidental Death & Dismemberment (AD&D) provides benefits due to certain injuries or death from an accident.* The covered injuries or death can occur up to 180 days after the accident. The AD&D Insurance pays certain percentages of the benefit amount based on the injury sustained. Refer to the certificate of coverage for the complete AD&D Benefit schedule. Coverage includes 10% additional benefit to a maximum of $10,000 for use of Seatbelt only or an additional 10% to a maximum of $20,000 for use of Seatbelt and Air Bag for loss of life. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage provided to you. **Some state variations may apply.*
What is a beneficiary?	Your beneficiary is a person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered under the policy. You, as the employee, must select your beneficiary when you complete your enrollment application; your selection is legally binding. You are automatically the beneficiary for any Spouse or Child(ren) coverage.
Are any resources available for beneficiaries?	**Beneficiary Services:** Provides beneficiaries with services for grief consultation, financial/legal assistance and referral to community resources. For more information, call **866-302-4480**. See below for more details.
Are there other limitations to enrollment?	You must be Actively at Work with your employer on the day your coverage takes effect. This coverage, like most group benefit insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the insurance coverage that you have elected may not be in effect.
Does my coverage reduce as I get older?	Employee Basic Life and AD&D and Supplemental Life and AD&D coverage reduces to 65% of the face amount at age 65; to 50% of the original amount at age 70. Spouse Supplemental Life and AD&D coverage reduces the same as the employee's. All coverage terminates upon employee's retirement.
Do I still pay my Life Insurance premiums if I become disabled?	If you become totally disabled before age 60 and your disability lasts for at least 9 months, your Employee Supplemental Life Insurance premium may be waived.
What is Accelerated Death Benefit?	If you are diagnosed as terminally ill with a 12 month or less life expectancy, you may receive payment of a portion of your Life Insurance. The remaining amount of your Life Insurance would be paid to your beneficiary when you die.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

UnitedHealthcare®

Basic Life and AD&D Insurance
Supplemental Life and AD&D Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

Can I keep my Life coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group Life coverage to your own individual policy (policies). • If you leave your employer, Portability is an option that allows you to continue your Supplemental Life Insurance coverage. To be eligible, you must terminate your employment prior to age 70. This option allows you to continue all or a portion of your Life Insurance coverage under a separate Portability term policy. Portability is subject to a minimum of $5,000 and a maximum of $500,000 and does include coverage for your Spouse and Children. You must elect portability for your own coverage in order to elect portability for your Spouse and or Children. To elect Portability, you must apply and pay the premium within 30 days of the termination of your Life Insurance. Dependent Spouse Portability is subject to a maximum of $250,000. Dependent Child Portability is subject to a maximum of $10,000.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

UnitedHealthcare®

Basic Life and AD&D Insurance
Supplemental Life and AD&D Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

LIFE AND AD&D COST SUMMARY (Current Monthly Rates)

Basic Life and AD&D – Employee	100% Company Paid
Supplemental Life and AD&D Employee and Spouse Age is based on employee's age	**Current Monthly Rates per $1,000 of benefit** **Age Range** — **Rate** Ages less than 25 — $0.090 Ages 25-29 — $0.090 Ages 30-34 — $0.090 Ages 35-39 — $0.110 Ages 40-44 — $0.160 Ages 45-49 — $0.230 Ages 50-54 — $0.370 Ages 55-59 — $0.630 Ages 60-64 — $1.020 Ages 65-69 — $1.570 Ages 70-74 — $2.530 Ages 75+ — $2.530
Supplemental Life and AD&D – Child(ren)	$0.29 per $1,000 of benefit

Premium Calculation Samples

Supplemental Life and AD&D
- Employee, age 36: $100,000 x $0.11 = $11,000 ÷ $1,000 x 12 ÷ 24 = $5.50 Semi-Monthly
- Spouse: $20,000 x $0.11 = $2,200 ÷ $1,000 x 12÷ 24 = $1.10 Semi-Monthly
- Child(ren): $10,000 x $0.29 = $2,900 ÷ $1,000 x 12÷24 = $1.45 Semi-Monthly

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UnitedHealthcare®

Basic Life and AD&D Insurance
Supplemental Life and AD&D Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

Important Details

Exclusions:

AD&D Insurance does not cover losses caused by or contributed by:

Disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, commission of an assault or felony, war, use of any drug unless prescribed by physician, driving while intoxicated, engaging in any hazardous activities, or travel in a private aircraft.*

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

As is standard with most term life Insurance, this Insurance coverage includes certain limitations and exclusions:

- Death by suicide (two years)*.

** Some state variations may apply*

Value-Added Services (All features may not apply. Some states may have restrictions.)

Beneficiary Services: Provides beneficiaries with services for grief consultation, financial/legal assistance and referral to community resources. **For more information, call 866-302-4480.**

- Toll-free line available 24/7 as well as referrals for face-to-face counseling. Specialists provide in-depth consultation, information and referral to community resources such as grief support groups. Includes access to a national network of credentialed clinicians for grief and loss counseling. Beneficiaries receive two complimentary sessions.**
- Financial and Legal Services. Telephonic access to financial consultants for assistance with financial decision-making. Includes access to a network of 22,000 attorneys for either a 30-minute telephonic or an in-person consultation. Clients may retain the same attorney for representation at a discounted rate. CLC, Inc. provides access to legal services.
- Communication Support. We provide a "Beneficiary Kit" with informational resources to help beneficiaries with the emotional and financial process that follows the loss of a loved one.

Wealth Management Account: An enhanced benefit payment process. Life claim proceeds in excess of $5,000 will automatically be deposited into an OptumBank Wealth Management Account (WMA). Beneficiaries receive an FDIC-insured, beneficiary-owned, interest earning account with convenient access to their claim proceeds via debit card or checkbook.***

**Beneficiary Services offered thru United Behavioral Health, a company of UnitedHealth Group.
***Eligibility for automatic deposit into an OptumHealth Bank Wealth Management Account is subject to qualifying conditions evaluated by OptumHealth Bank and UnitedHealthcare Specialty Benefits at the time of claim review to include limited availability in certain states. For more information please contact your Specialty Benefits representative. OptumHealth Bank, Member FDIC, is part of the financial services unit of OptumHealth, a health and wellness company serving more than 60 million people. OptumHealth is a UnitedHealth Group (NYSE:UNH) company.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company; Unimerica Insurance Company; and in California by Unimerica Life Insurance Company; and in New York by Unimerica Life Insurance Company of New York. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5. UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Insurance Company and Unimerica Life Insurance Company in Milwaukee, WI; Unimerica Life Insurance Company of NY in New York, NY.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

UnitedHealthcare®

Employer-Paid Short Term Disability Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

Am I eligible?	You are eligible if you are an All Other Active, Full-Time Employee excluding Directors and Texas Employees who works at least 30 hours per week.
What is Short Term Disability Insurance?	Employer-Paid Short Term Disability Insurance pays you a portion of your Earnings if you cannot work because of a disabling illness or injury. This highlight sheet is an overview of your Short Term Disability Insurance. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.
Why do I need Short Term Disability Insurance?	Short Term Disability Insurance protects the financial security for you and your family. The ability to earn an income is something to be protected – disabilities happen, and they happen more frequently than most think. Can you afford to be disabled? ***Did You Know:*** 3 in 10 workers will be disabled for more than 90 days before the age of 65. 71% of Americans would find it very difficult or somewhat difficult to meet their current financial obligations if their next paycheck were delayed for one week. **http://www.disabilitycanhappen.org**
What is disability?	The Covered Person is Disabled or has a Disability when We determine that: 1. you are not Actively at Work and are unable to perform some or all of the Material and Substantial Duties of your regular Occupation due to your Sickness or Injury; and 2. you have a 20% or more loss in Pre-Disability Weekly Earnings due solely to the same Sickness or Injury; and 3. you are under the Regular Care of a Physician. Disability must begin while the Covered Person is insured under the Policy.
How much coverage would I have?	Your Employer provides, at no cost to you, Short Term Disability Insurance that would pay you a benefit of 60% of your weekly Earnings. The maximum Employer Paid Short Term Disability Insurance benefit you could receive is $462 per week. Earnings are defined in the UnitedHealthcare contract with your employer.
How long do I have to wait before I start to receive payment? (Elimination Period)	Once you are approved for coverage, you will be eligible to collect your Short Term Disability Insurance benefit starting on the 14th day after your accident or 14th day of sickness. Your benefit could continue for up to 11 weeks.
If I am disabled, can the amount of my benefit be reduced?	As described later in this summary, your weekly Short Term Disability benefit may be reduced by other income you receive.
Are there other limitations to enrollment?	You must be Actively at Work with your employer on the day your coverage takes effect.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

UnitedHealthcare®

Employer-Paid Short Term Disability Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

Important Details

This Benefit Highlights Sheet is an overview of the Short Term Disability Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

Exclusions:

You cannot receive Short Term Disability Insurance benefit payments for disabilities that are caused or contributed to by:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Sickness or injury for which Workers' Compensation benefits are paid, or may be paid, if duly claimed
- Any injury sustained as a result of doing any work for pay or profit for another employer

You must be under the regular care of a physician to receive benefits.

Your benefit payments **will be reduced** by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Employer's sick leave or salary continuation plan.
- Loss of time or loss lost wages from no-fault motor vehicle insurance plan.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

UnitedHealthcare®

Employer- Paid Long Term Disability Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

Am I eligible?	You are eligible if you are Other FTA Employees working 30+ hours per week.
What is Long Term Disability Insurance?	Long Term Disability Insurance pays you a portion of your Earnings if you cannot work because of a disabling illness or injury. This highlight sheet is an overview of your Long Term Disability Insurance. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.
Why do I need Long Term Disability Insurance?	Long Term Disability Insurance protects the financial security for you and your family. The ability to earn an income is something to be cherished and protected – disabilities happen, and they happen more frequently than most think. Can you afford to be disabled? **Did You Know:** 3 in 10 workers will be disabled for more than 90 days before the age of 65. Many American families live paycheck to paycheck, and the majority could not afford to go one month or one week, let alone 2 or 3 years, without the support of regular income. **http://www.disabilitycanhappen.org**
What is disability?	Disability is defined in the UnitedHealthcare contract with your employer. The Covered Person is Disabled or has a Disability when We determine that: 1. you are not Actively at Work and are unable to perform some or all of the Material and Substantial Duties of your Regular Occupation due to your Sickness or Injury; and 2. you have a 20% or more loss in Indexed Pre-Disability Monthly Earnings due solely to the same Sickness or Injury; and 3. you are under the Regular Care of a Physician. Disability must begin while the Covered Person is insured under the Policy. After 24 months of payments, the Covered Person is Disabled when We determine that due to the same Sickness or Injury, you are unable to perform some or all of the material and substantial duties of any Gainful Occupation for which you are reasonably fitted by education, training or experience and you continue to suffer a 20% or more loss in Indexed Pre-Disability Monthly Earnings due solely to the Sickness or Injury.
How much coverage would I have?	Your Employer provides, at no cost to you, Long Term Disability Insurance that would pay you a benefit of 60% of your monthly Earnings to a maximum monthly benefit of $2,000 per month. Earnings are defined in the UnitedHealthcare contract with your employer.
How long do I have to wait before I can receive payment? (Elimination Period)	You must be disabled for at least 90 days before you can receive a Long Term Disability Insurance benefit payment.
Are there other limitations to enrollment?	You must be Actively at Work with your employer on the day your coverage takes effect.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

UnitedHealthcare®

Employer- Paid Long Term Disability Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

How long will my disability payments continue?	For as long as you remain disabled, or until you reach your Social Security Normal Retirement Age (as stated in the 1983 revision of the United States Social Security Act.), whichever is sooner. If your disability occurs at age 60 or above, your payments may be reduced.
Can the duration or amount of my benefit be reduced?	Yes. Your benefit duration may be reduced once you reach certain ages specified in the in chart below. **Maximum Benefit Period:** Reducing Benefit Duration reflecting Social Security Normal Retirement Age **Age at Disability** — **Maximum Benefit Period** Greater of SSNRA * or Less than age 60 — To age 65 Age 60 — 60 Months Age 61 — 48 Months Age 62 — 42 Months Age 63 — 36 Months Age 64 — 30 Months Age 65 — 24 Months Age 66 — 21 Months Age 67 — 18 Months Age 68 — 15 Months 69 and over — 12 Months **SSNRA means the Social Security Normal Retirement Age as figured by the 1983 amendment or any later amendment to the Social Security Act.* In addition, as described below within the Important Details, your monthly Long-Term Disability benefit may be reduced by other income you receive.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

UnitedHealthcare®

Employer- Paid Long Term Disability Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

Important Details:

This Benefit Highlights Sheet is an overview of the Long Term Disability Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the insurance policy, the terms of the insurance policy apply. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

Exclusions:
You cannot receive Long Term Disability Insurance benefit payments for disabilities that are caused or contributed to by:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability

You must be under the regular care of a physician to receive benefits.

Mental Illness, Alcoholism or Substance Abuse:

- You can receive benefit payments for Long-Term Disabilities resulting from mental illness, alcoholism and substance abuse for a total of 24 months for all disability periods during your lifetime.
- Any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 months lifetime limit.

Pre-Existing Condition Exclusion:
We will not cover any Disability that begins during the first 12 months after the Covered Person's Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.
Pre-Existing Condition means: any Sickness or Injury including Mental Illness, Substance Abuse for which the Covered Person, within 3 months prior to his Effective Date of insurance:

1. was diagnosed by or received Treatment from a legally qualified Physician; or
2. had symptoms for which an ordinarily prudent person would have sought Treatment.

Your benefit payments **will be reduced** by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance (please see next section for exceptions)
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Loss of time or lost wages from a no-fault motor vehicle insurance plan.
- Benefits from Employer's sick leave of salary continuation plan.

This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.

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Employer- Paid Long Term Disability Insurance

ABC Imaging, LLC
Summary of Benefits Effective: 12.1.15

Your benefit payments **will not be reduced** by certain kinds of other income, such as:

- Retirement benefits if you were already receiving them before you became disabled
- Retirement benefits that are funded by your after-tax contributions
- Your personal savings, investments, IRAs or Keoghs
- Profit-sharing
- Most personal disability policies
- Social Security increases

Member Assistance Program:

The Member Assistance Program, which accompanies your Long Term Disability benefit, comes at no additional cost to the employee. It includes personal and confidential assistance for employees and their families.
• Toll-free Member Assistance line
• 24/7 access to liveandworkwell.com.
• Referral for face-to-face counseling
• Legal and Financial services information and referrals*

** May not be available in all states.*

Disability insurance

Member Assistance Program

For long-term disability members.

Life is stressful, and sometimes the constant challenges can become overwhelming. When you have unresolved problems, it can take a serious toll on both your work and home life.

To help you through difficult times, we offer a Member Assistance program as part of our long-term disability plan.* The program offers members and their families personal and confidential support that's available 24 hours a day, 7 days a week. With just one call, you can get the following types of assistance:

- Counseling services
- Help with financial and legal issues
- Family support
- Help with relationships, coping and depression

Consultation services are provided by experienced master's-level specialists who offer personal assistance and referrals to a network of licensed and certified clinicians for up to three face-to-face counseling sessions, if desired. We also help connect you to attorneys for legal assistance or mediation, as well as consultation with financial professionals.

Member Assistance Program

- Members and their families can get confidential assistance at **1-877-660-3806**
- TDD/TTY users can call **711** for relay service. Once connected, please provide the number listed above.
- Translators available for non-English speakers
- Visit **liveandworkwell.com** to access tools and information to help you enhance your health and well-being

– There are two ways to login:

1) create your own user name and password under "Members: Login or Register"; OR

2) use the access code "LTDEAP" under "Guest Access"

* Member assistance services offered through Optum. Optum is a subsidiary of UnitedHealth Group.

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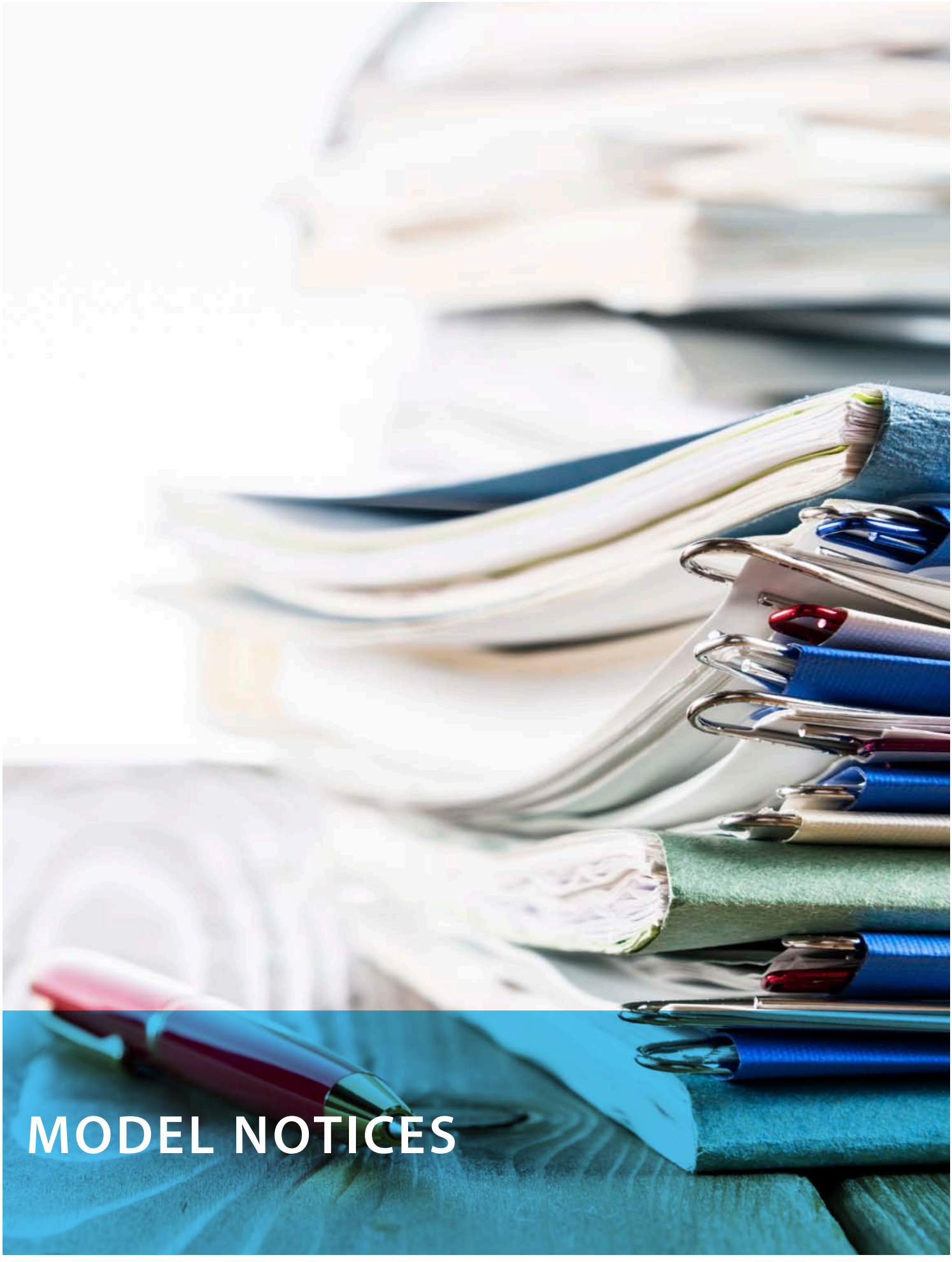

MODEL NOTICES

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "30 days'' or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days'' or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact

Date:	12/1/2017
Name of Entity/Sender:	ABC Imaging of Washington, Inc.
Contact-Position Office:	Barbara Hoey
Address:	5290 Shawnee Road Suite 300 Alexandria VA 22312
Phone Number:	202-429-8870 ext. 1350

WOMEN'S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. This coverage is subject to the deductibles, co-pay and co-insurance amounts that apply to the medical plan in which you are enrolled. Please refer to your plan summary.

If you would like more information on WHCRA benefits, call your Plan Administrator at 202-429-8810.

IMPORTANT NOTICE FROM ABC IMAGING OF WASHINGTON, INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ABC Imaging of Washington, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. ABC Imaging of Washington, Inc. has determined that the prescription drug coverage offered by the Carefirst is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current ABC Imaging of Washington, Inc. coverage may be affected. The current prescription plan is creditable. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current ABC Imaging of Washington, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with ABC Imaging of Washington, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information.NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ABC Imaging of Washington, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember:
Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	12/1/2017
Name of Entity/Sender:	ABC Imaging of Washington, Inc.
Contact-Position Office:	Barbara Hoey
Address:	5290 Shawnee Road, Suite 300, Alexandria VA 22312
Phone Number:	202-429-8870 ext. 1350

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

Alabama | Medicaid	
http://myalhipp.com	855-692-5447
Alaska | Medicaid	
The AK Health Insurance Premium Payment Program Website http://myakhipp.com	
Email CustomerService@MyAKHIPP.com	866-251-4861
Medicaid Eligibility http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	
Arkansas | Medicaid	
http://myarhipp.com	855-692-7447
Colorado | Medicaid	
http://www.colorado.gov/hcpf	800-221-3943
Florida | Medicaid	
http://flmedicaidtplrecovery.com/hipp	877-357-3268
Georgia | Medicaid	
http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP)	404-656-4507

Indiana | Medicaid	
Healthy Indiana Plan for Low-Income Adults 19-64 http://www.hip.in.gov	877-438-4479
All Other Medicaid http://www.indianamedicaid.com	800-403-0864
Iowa | Medicaid	
http://www.dhs.state.ia.us/hipp/	888-346-9562
Kansas | Medicaid	
http://www.kdheks.gov/hcf/	785-296-3512
Kentucky | Medicaid	
http://chfs.ky.gov/dms/default.htm	800-635-2570
Louisiana | Medicaid	
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	888-695-2447
Maine | Medicaid	
http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-442-6003 TTY: Maine Relay 711
Massachusetts | Medicaid and CHIP	
http://www.mass.gov/MassHealth	800-462-1120

Minnesota | Medicaid	
http://mn.gov/dhs/ma	800-657-3739
Missouri | Medicaid	
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana | Medicaid	
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	800-694-3084
Nebraska | Medicaid	
http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx	855-632-7633
Nevada | Medicaid	
http://dwss.nv.gov/	800-992-0900
New Hampshire | Medicaid	
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf	603-271-5218
New Jersey | Medicaid and CHIP	
Medicaid http://www.state.nj.us/humanservices/dmahs/clients/medicaid/	609-631-2392
CHIP http://www.njfamilycare.org/index.htm	800-701-0710
New York | Medicaid	
http://www.nyhealth.gov/health_care/medicaid/	800-541-2831
North Carolina | Medicaid	
http://www.ncdhhs.gov/dma	919-855-4100
North Dakota | Medicaid	
http://www.nd.gov/dhs/services/medicalserv/medicaid/	844-854-4825
Oklahoma | Medicaid and CHIP	
http://www.insureoklahoma.org	888-365-3742
Oregon | Medicaid and CHIP	
http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov	800-699-9075

Pennsylvania | Medicaid	
http://www.dhs.pa.gov/hipp	800-692-7462
Rhode Island | Medicaid	
http://www.eohhsri.gov	401-462-5300
South Carolina | Medicaid	
http://www.scdhhs.gov	888-549-0820
South Dakota | Medicaid	
http://dss.sd.gov	888-828-0059
Texas | Medicaid	
http://gethipptexas.com	800-440-0493
Utah | Medicaid and CHIP	
Medicaid http://health.utah.gov/medicaid **CHIP** http://health.utah.gov/chip	877-543-7669
Vermont | Medicaid	
http://www.greenmountaincare.org	800-250-8427
Virginia | Medicaid and CHIP	
http://www.coverva.org/programs_premium_assistance.cfm	**Medicaid** 800-432-5924 **CHIP** 855-242-8282
Washington | Medicaid	
http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx	800-562-3022 ext. 15473
West Virginia | Medicaid	
http://www.dhhr/wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx	877-598-5820, HMS Third Party Liability
Wisconsin | Medicaid and CHIP	
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	800-362-3002
Wyoming | Medicaid	
https://wyequalitycare.acs-inc.com/	307-777-7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Center for Medicare & Medicaid Services
www.cms.hhs.gov
1-877267-2323, Menu Option 4, Ext. 61565

GLOSSARY OF INSURANCE TERMS

BALANCE BILLING
An out-of-network healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

CO-INSURANCE
The percentage of costs of a covered health care service you pay after you've paid your deductible.

CO-PAYMENT
A fixed amount you pay for a covered health care service.

DEDUCTIBLE
The amount you pay for covered health care services before your insurance plan starts to pay.

EMERGENCY SERVICES
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

FORMULARY
A list of prescription drugs that are covered by your health insurance plan. The formulary is separated into cost levels called tiers, which affects how much you pay for each drug. Also known as a Prescription Drug List (PDL).

HEALTH SAVINGS ACCOUNT (HSA)
A tax advantaged savings account that is owned by you and can be funded with tax-free contributions for the purpose of paying for qualified health care expenses today and in the future. HSA's can only be funded by those who are enrolled in a Qualified High Deductible Health Plan (HDHP).

MAXIMUM ALLOWABLE CHARGE (MAC)
Similar to UCR, the MAC is what the insurance carriers determines to be the maximum amount that can be charged for a dental service in a geographic area based on what providers in the area usually charge for the same or similar dental services.

NON-PREFERRED PROVIDER
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

OUT-OF-POCKET MAXIMUM
The most you could pay during a plan year for your share of the costs of covered services. After you meet this limit the plan will pay 100% of the allowed amount.

PRE-AUTHORIZATION
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug is medically necessary.

PREFERRED PROVIDER
A provider who has a contract with your health insurer or plan to provide services to you at a discount.

PREMIUM
The cost of your health insurance or plan each month. This amount is shared by you and your employer.

PRIMARY CARE PHYSICIAN
A physician who directly provides or coordinates a range of health care services for a patient.

PRIMARY CARE PROVIDER
A physician, nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

SPECIALIST
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

UCR (USUAL, CUSTOMARY AND REASONABLE)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical services. The UCR amount sometimes is used to determine the allowed amount.

URGENT CARE
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

PAYROLL CONTRIBUTIONS PER PAY PERIOD

UnitedHealthcare Choice Plus POS Plan ASZJ Modified	
Employee Only	$171.96
Employee + Child(ren)	$425.30
Employee + Spouse	$559.17
Family	$707.44
UnitedHealthcare Choice HMO Plan ASXR Modified HSA	
Employee Only	$126.03
Employee + Child(ren)	$340.32
Employee + Spouse	$453.52
Family	$578.99
Optimum Choice HMO Plan AO-9S Modified HSA Plan AE9L | DC Metro Employees Only	
Employee Only	$109.77
Employee + Child(ren)	$296.42
Employee + Spouse	$394.99
Family	$504.32
UnitedHealthcare Dental | High Plan	
Employee Only	$18.49
Employee + Child(ren)	$48.83
Employee + Spouse	$40.20
Family	$69.03
UnitedHealthcare Dental | Low Plan	
Employee Only	$12.70
Employee + Child(ren)	$25.40
Employee + Spouse	$29.94
Family	$42.64
UnitedHealthcare Vision	
Employee Only	$1.42
Employee + Child(ren)	$3.77
Employee + Spouse	$3.84
Family	$6.82

UnitedHealthcare Life & Disability	
Basic Life/AD&D	100% Employer Paid
Short Term Disability	100% Employer Paid
Long Term Disability	100% Employer Paid
UnitedHealthcare Voluntary Life	
Voluntary Life/AD&D	100% Employee Paid

KEY CONTACTS

HAVE QUESTIONS, PROBLEMS OR CONCERNS?

Should you need any personal assistance understanding your benefits, claims or other insurance related information, the following are your carrier contact numbers and websites. There is a wealth of information regarding your plans, claims and other online resources. We recommend that your first step be to call the insurance carrier. You will need your ID number or Social Security Number along with the date of service and provider name (when applicable). If you require further assistance, please contact your Client Advocate at The Meltzer Group or Human Resources. Please have the same information available when contacting The Meltzer Group or Human Resources.

Medical	**UnitedHealthcare**	866-873-3903 www.myuhc.com
Dental	**UnitedHealthcare**	800-445-9090 www.myuhcdental.com
Vision	**UnitedHealthcare**	800-638-3120 www.myuhcvision.com
Life & Disability	**UnitedHealthcare**	888-866-3192 www.uhc.com
Member Assistance Program	**UnitedHealthcare**	877-660-3806 www.liveandworkwell.com
ABC Imaging of Washington, Inc.	**Human Resources**	202-429-8870 ext. 1350 hr@abcimaging.com
The Meltzer Group	**Christopher M. Romano** Senior Vice President	301-581-7374 cromano@meltzergroup.com
The Meltzer Group	**Darlene Sebring** Senior Account Manager	301-214-7012 dsebring@meltzergroup.com
The Meltzer Group	**Senta Bennett** Senior Client Advocate	301-581-7344 sbennett@meltzergroup.com

This benefit brochure is only intended as a brief summary of your benefits. Please note that all Benefits are subject to the contractual terms, limitations and exclusions as set forth in the master contracts of the carriers. If this summary conflicts in any way with the carrier Certificate of Coverage (COC), Riders and/or Amendments, those documents shall prevail. It is highly recommended that you review the carrier COC 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.