UnitedHealthcare®

Benefit Summary

ASO Choice Plus
Olympic Steel, Inc.
Medical Plan Name: Choice Plus UHPD PPO Plan

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

United HealthCare Services, Inc. and Olympic Steel, Inc. want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

Your Costs

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

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		
What is an annual deductible? The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible. • Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service. • All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible – Individual	$1,000 per year.	$2,000 per year.
Medical Deductible - Family	$3,000 per year.	$6,000 per year.
Out-of-Pocket Limit		
What is an out-of-pocket limit? The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. • Your co-pays, co-insurance, and deductibles (including pharmacy) count towards meeting the out-of-pocket limit. • 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	$5,000 per year.	$5,500 per year.
Out-of-Pocket Limit – Family	$10,000 per year.	$11,000 per year.

Your Costs

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

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Ambulance Services			
Emergency Ambulance:	20% co-insurance	Same as Network.	Network: Yes Out-of-Network: Yes Network Deductible applies to Out-of-Network benefits.
Non-Emergency Ambulance:	20% co-insurance	Same as Network.	Network: Yes Out-of-Network: Yes Network Deductible applies to Out-of-Network benefits.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.	
Cellular and Gene Therapy			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	Out-of-Network Benefits are not available	Deductible will be based on where the covered health care service is provided.
Clinical Trials			
	The amount you pay is based on where the covered health care service is provided.		Deductible will be based on where the covered health care service is provided.

Your Costs

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

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
	Prior Authorization is required.	Prior Authorization is required.	
Congenital Heart Disease (CHD) Surgeries			
	Benefits will be the same as stated under Hospital - Inpatient Stay.		Deductible will be the same as stated under Hospital - Inpatient Stay.
		Prior Authorization is required.	
Dental Services – Accident Only			
Treatment completed within 12 months of the accident.	20% co-insurance	Same as Network. Out-of-Network limited to $3,000 per calendar year.	Network: Yes Out-of-Network: Yes Network Deductible applies to Out-of-Network benefits.
Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.		Deductible will be based on where the covered health care service is provided.
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider.		
		Prior Authorization is required for DME that costs more than $1,000.	
Durable Medical Equipment (DME) , Orthotics and Supplies			
Repair and replacement is covered when prescribed by a physician.	20% co-insurance	40% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required for DME or orthotics that costs more than $1,000.	
Emergency Health Care Services - Outpatient			
	$200 co-pay per visit	Same as Network.	Network: No Out-of-Network: No
		Notification is required if confined in an Out-of-Network Hospital.	
Gender Dysphoria			
	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.		Deductible will be based on where the covered health care service is provided.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.	
Habilitative Services			
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.		Deductible will be based on where the covered health care service is provided.
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.	$25 co-pay per visit	40% co-insurance	Network: No Out-of-Network: Yes
		Prior Authorization is required for certain Inpatient services.	
Home Health Care			
Limited to 100 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.	20% co-insurance	40% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required.	

Your Costs

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

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Hospice Care			
	20% co-insurance	40% co-insurance Prior Authorization is required for Inpatient Stay.	Network: Yes Out-of-Network: Yes
Hospital – Inpatient Stay			
	20% co-insurance	40% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing – Outpatient	Designated Network: You pay nothing. A deductible does not apply. Network: 20% co-insurance (Covered in full if performed as part of an office visit, or if provided at a free-standing facility or independent lab)	40% co-insurance	Network: Yes Out-of-Network: Yes
X-Ray and Other Diagnostic Testing - Outpatient	20% co-insurance (X-ray covered in full if performed as part of an office visit.)	40% co-insurance Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.	Network: Yes Out-of-Network: Yes
Major Diagnostic and Imaging - Outpatient			
	20% co-insurance	40% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Mental Health Care and Substance – Related and Addictive Disorders Services			
Inpatient:	20% co-insurance	40% co-insurance	Network: No Out-of-Network: Yes
Outpatient:	$25 co-pay per visit	40% co-insurance	Network: No Out-of-Network: Yes
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance	40% co-insurance Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.	Network: Yes Out-of-Network: Yes
Ostomy Supplies			
	20% co-insurance	40% co-insurance	Network: Yes Out-of-Network: Yes
Pharmaceutical Products - Outpatient			
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	20% co-insurance	40% co-insurance	Network: Yes Out-of-Network: Yes
Physician Fees for Surgical and Medical Services			
Primary Care Visits	20% co-insurance	40% co-insurance	Network: Yes Out-of-Network: Yes
Specialist Care Visits	20% co-insurance		
Physician's Office Services – Sickness and Injury			
Primary Care Physician Office Visit	Designated Network: $10 co-pay per visit Network: $25 co-pay per visit	40% co-insurance	Network: No Out-of-Network: Yes
Specialist Office Visit	Designated Network: $25 co-pay per visit Network: $45 co-pay per visit		
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office.			
Pregnancy – Maternity Services			
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.	Deductible will be based on where the covered health care service is provided.
Preventive Care Services			

Your Costs

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

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing	40% co-insurance	Network: No Out-of-Network: Yes
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.			
Prosthetic Devices			
Repair and replacement is covered when prescribed by a physician.	20% co-insurance	40% co-insurance Prior Authorization is required for Prosthetic Devices that costs more than $1,000.	Network: Yes Out-of-Network: Yes
Reconstructive Procedures			
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.	Deductible will be based on where the covered health care service is provided.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment			
Benefits are limited per year as follows: 60 combined visits of physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation therapy 12 visits of Manipulative Treatment 36 visits of cardiac rehabilitation therapy 30 visits of post-cochlear implant aural therapy	$25 co-pay per visit	40% co-insurance	Network: No Out-of-Network: Yes
Scopic Procedures – Outpatient Diagnostic and Therapeutic			
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance	40% co-insurance	Network: Yes Out-of-Network: Yes
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services			
Limited to 120 days each skilled nursing and inpatient rehabilitation per year.	20% co-insurance	40% co-insurance Prior Authorization is required.	Network: Yes Out-of-Network: Yes
Surgery – Outpatient			
	20% co-insurance	40% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Therapeutic Treatments – Outpatient			
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance	40% co-insurance Prior Authorization is required for certain services.	Network: Yes Out-of-Network: Yes
Transplantation Services			
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	40% co-insurance Prior Authorization is required.	Deductible will be based on where the covered health care service is provided.
Urgent Care Center Services			
	$50 co-pay per visit	40% co-insurance	Network: No Out-of-Network: Yes
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility.			
Virtual Visits			
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$0 co-pay per visit	Out-of-Network Benefits are not available.	Network: No Out-of-Network: Out-of-Network Benefits are not available.

Additional Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Obesity – Weight Loss Surgery			
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	The amount you pay is based on where the covered heath care service is provided. Prior Authorization is required.	Deductible will be based on where the covered health care service is provided.
Temporomandibular Joint Services			
	The amount you pay is based on where the covered health care service is provided.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required for Inpatient Stay.	Deductible will be based on where the covered health care service is provided.
Vision Exams			
	The amount you pay is based on where the covered health care service is provided.	40% co-insurance	Network: No Out-of-Network: Yes
Wigs			
Limited to 1 wig per calendar year. Covered for hair loss as the result of cancer treatment. Replacement is covered when prescribed by a physician.	20% co-insurance	40% co-insurance	Network: Yes Out-of-Network: Yes

Exclusions and Limitations

This is a partial list of services that your plan generally does not cover. It does not include all of the services that are not covered. It is important that you review Section 2: Exclusions and Limitations in your Summary Plan Description 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.

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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