Schedule of Benefits

Hillsborough Community College

2023-203649-1

METALLIC LEVEL – [TBD] WITH ACTUARIAL VALUE OF [TBD]%

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible Preferred Provider	$500 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$1,000 (Per Insured Person, Per Policy Year)]
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	60% except as noted below
Out-of-Pocket Maximum Preferred Provider	$6,350 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$12,700 (Per Insured Person, Per Policy Year)

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

The **Preferred Provider** for this plan is UnitedHealthcare Choice Plus.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider. Refer to the *Preferred Provider and Out-of-Network Provider Information* section of the Certificate for information on reimbursement for Emergency Services provided by an Out-of-Network Provider, Covered Medical Expenses provided at certain Preferred Provider facilities by an Out-of-Network Physician, and Air Ambulance transport provided by an Out-of-Network Provider.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network Provider Benefits. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Note: No benefits will be paid for services designated as "No Benefits" in the Schedule.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network Provider unless otherwise specifically stated. Please refer to the Medical Expense Benefits section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	Allowed Amount after Deductible	Allowed Amount after Deductible
Intensive Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Miscellaneous Expenses	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery	Allowed Amount after Deductible	Allowed Amount after Deductible

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.		
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Registered Nurse's Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	Allowed Amount after Deductible	Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	Allowed Amount after Deductible	Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	$25 Copay per visit Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Physiotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Limits for each Injury or Sickness as follows: 35 visits of physical therapy 35 visits of occupational therapy 35 visits of speech therapy 35 visits for cardiac rehabilitation therapy Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services See also Benefits for Cleft Lip and Cleft Palate		
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$250 Copay per visit Allowed Amount not subject to Deductible	$250 Copay per visit 80% of Allowed Amount not subject to Deductible
Diagnostic X-ray Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Tests & Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Injections	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Rider for additional information	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $25 Copay per prescription Tier 1 $40 Copay per prescription Tier 2 $50 Copay per prescription Tier 3 up to a 30-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	$25 Copay per prescription generic drug $40 Copay per prescription brand-name drug 100% of billed charge up to a 30-day supply per prescription not subject to Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Durable Medical Equipment	Allowed Amount after Deductible	Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Consultant Physician Fees	$25 Copay per visit Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only. See Section 10 for Dental Benefits	Allowed Amount after Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid for removal of impacted wisdom teeth only.	Allowed Amount after Deductible	Allowed Amount after Deductible
Mental Illness Treatment	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $25 Copay per visit Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible
Substance Use Disorder Treatment	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $25 Copay per visit Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	Allowed Amount after Deductible	Allowed Amount after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	Allowed Amount after Deductible
Reconstructive Breast Surgery Following Mastectomy See Benefits for Mastectomies, Prosthetic Devices and Reconstructive Surgery	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Diabetes Services See Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospice Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Inpatient Rehabilitation Facility 21 days maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Skilled Nursing Facility 60 days maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Urgent Care Center	$25 Copay per visit Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See riders attached for Pediatric Dental and Vision Services benefits	See riders attached for Pediatric Dental and Vision Services benefits
Bariatric Surgery	Allowed Amount after Deductible	Allowed Amount after Deductible
Tuberculosis Screening and Testing Tuberculosis screening, Quantiferon B Testing, including shots (Other than covered under preventive care services)	Allowed Amount after Deductible	Allowed Amount after Deductible

Section 12: Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acne.
2. Acupuncture.
3. Addiction, such as:
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
4. Learning disabilities.
5. Biofeedback.
6. Circumcision.
7. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Correct deformity caused by birth defects or growth defects.
8. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
9. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As specifically provided in the Schedule of Benefits.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
10. Elective Surgery or Elective Treatment, except cosmetic surgery made necessary as the result of a covered Injury or to correct a disorder of a normal bodily function.
11. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
12. Foot care for the following:
    - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

    This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
13. Health spa or similar facilities. Strengthening programs.
14. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of an infection or Injury.
    - Benefits for Cleft Lip and Cleft Palate.
15. Hirsutism. Alopecia.
16. Hypnosis.
17. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
18. Injury or Sickness for which benefits are paid or payable by the prior insurer to the extent of its accrued liability and extension of benefit or benefits period as required by F.S. 627.667.
19. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
20. Injury sustained while:
    - Participating in any intercollegiate or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
21. Investigational services.
22. Lipectomy.
23. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
24. Prescription Drugs, services or supplies as follows, except as specifically provided in the Policy:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.

- Immunization agents, except as specifically provided in the Policy.
- Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
- Products used for cosmetic purposes.
- Drugs used to treat or cure baldness. Anabolic steroids used for body building.
- Anorectics - drugs used for the purpose of weight control.
- Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
- Growth hormones.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

25. Reproductive services for the following, except as specifically provided in the Policy:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Fertility tests.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
    - Premarital examinations.
    - Reversal of sterilization procedures.
26. Research or examinations relating to research studies, or any treatment for which the patient or the patient’s representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.
27. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To Physician services, soft lenses or sclera shells for the treatment of aphakic patients.
    - To initial glasses or contact lenses following cataract surgery.
    - To benefits specifically provided in Pediatric Vision Services.
28. Preventive care services which are not specifically provided in the Policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.
29. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
30. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
31. Skydiving. Hang gliding. Parasailing. Sail planing. Bungee jumping.
32. Sleep disorders.
33. Speech therapy, except as specifically provided in Benefits for Cleft Lip and Cleft Palate, or except as specifically provided in the Policy. Naturopathic services.
34. Supplies, except as specifically provided in the Policy.
35. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided in the Policy.
36. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:
    - Recreational vehicle for: four-wheeled all terrain vehicle (ATV).
37. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
38. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
39. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date.

If an Insured is Totally Disabled on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 12 months after the Termination Date.

If an Insured is pregnant on the Termination Date and the conception occurred while covered under this Policy, Covered Medical Expenses for such pregnancy will continue to be paid through the term of the pregnancy.

If an Insured is receiving dental treatment on the Termination Date for a covered dental procedure, Covered Medical Expenses for such dental procedures will continue to be paid subject to all of the following:

1. The course of treatment or dental procedure was recommended in writing and commenced, in connection with a specific Injury or Sickness incurred while the Policy was in effect, by the attending Physician or dentist to the Insured while the Insured was covered by the Policy.

2. The dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services.

3. The dental procedures were performed within 90 days after the Insured's coverage ceased under the Policy and the termination of coverage did not occur as a result of the Insured's, or in the case of a Dependent child, the child's parents voluntary termination of coverage.

4. The extension of benefits for dental procedures terminates upon the earlier of:

    - The end of the 90-day period specified in 3 above.
    - The date the Insured becomes covered under a succeeding policy providing coverage or services for similar dental procedures. If coverage or services for the dental procedures are excluded by the succeeding policy through the use of an elimination period, the Insured is not covered by the succeeding policy and the extension of benefits does not terminate.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the maximum benefit.

After this Extension of Benefits provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.