Benefits designed with care

Explore your plan options for:

Accident Protection Plan
Critical Illness Protection Plan
Hospital Indemnity Protection Plan

United Healthcare | HONDA

Supplemental health plan highlights

Accident Protection

Even with health insurance, an accidental injury can cost you thousands of dollars. Lost wages from missing work, health insurance deductibles and daily living expenses can create long-term financial problems. Accident insurance helps cover the added costs you or your covered family member may face following an injury.

How the plan works

If you have a covered injury during the plan year and submit a claim, the Accident Protection Plan will pay you a cash benefit directly. Any payment you receive is in addition to the benefits your health plan gives you. Plus, you don't have to meet a deductible to receive the money — and you can use the money any way you want.

- Benefits paid directly to you
- Convenient payroll deduction
- Guarantee issue coverage (no medical history questions to answer)
- Plan is portable
- Benefits are not affected by other insurance benefits

Critical Illness Protection

Enrolling in a UnitedHealthcare Critical Illness Protection Plan helps give you and your family more financial security if you or a covered family member is diagnosed with a covered illness.

How the plan works

The Critical Illness Protection Plan sends a lump-sum payment directly to you after diagnosis of a covered condition. The plan pays a lump-sum benefit for the diagnosis of a covered critical illness including, but not limited to:

- 12 conditions including heart attack, stroke and cancer
- 22 conditions covered under the partial benefits rider
- Coronavirus is included as a covered illness. The covered person must be:
  1. Diagnosed with Coronavirus by a physician with a positive Coronavirus test AND
  2. Confined in the hospital for 1 or more days (1 day means 20+ hours and confinement means inpatient in the hospital) within 14 days of the Coronavirus diagnosis.
- **A positive Coronavirus test or diagnosis alone will not result in benefit payment.**

The money is yours to use however you want, including paying for:

- Out-of-pocket health plan costs (deductibles, coinsurance, etc.)
- Mortgage or rent
- Groceries
- Prescriptions
- Treatment by a specialist
- Transportation to and from treatment

Hospital Indemnity Protection

Even with health insurance, a hospital stay can mean big out-of-pocket costs and stress. If you or a covered family member receives covered hospital care and submit a claim, the Hospital Indemnity Protection Plan will pay you directly in a single payment lump sum. Use the money any way you choose. This plan gives you the extra financial help you need so you can focus on feeling better.

Get a direct payment after hospital care

Covered hospital expenses include:

- Hospital admission
- Hospital confinement
- ICU confinement (For coverage details, see your official benefit plan documents)

Use the money any way you choose

Use your payments for:

- Health plan deductible and other costs, such as medications, rehabilitation and transportation
- Bills and living expenses
- Growing your savings account, even a Health Savings Account (HSA)

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For complete plan details, refer to the certificate of coverage.

Wellness benefit

Get screened, earn money

Your UnitedHealthcare Accident Protection Plan and Critical Illness Protection Plan include a wellness benefit that may put money in your pocket. You could earn up to $50 — for you and your covered spouse to use any way you'd like — just for completing screenings like blood tests, colonoscopies or stress tests. You and your insured spouse are eligible to receive $50 for one covered wellness test under the Accident Protection Plan and $50 for one covered wellness test under the Critical Illness Protection Plan, for a maximum benefit of $100 for 2 covered wellness tests for each insured individual and their spouse annually. Remember, this wellness benefit is applicable under the Accident and Critical Illness Plans but not the Hospital Indemnity Plan.

Benefit Assist

Being proactive goes a long way

If you are enrolled in the Honda UMR, UnitedHealthcare or BCBSAL health plans and one or more of the supplemental health plans, you also receive Benefit Assist. UnitedHealthcare will proactively review medical claims to determine if a supplemental health benefit may be payable. The result is a personalized experience that assists with the claim submission process. If you are not enrolled in the Honda UMR, UnitedHealthcare or BCBSAL health plans, you can submit your supplemental health claim on your own. (See next section.)

Members can also initiate claims

To submit your own supplemental health plan claim, you can visit the member portal at **myuhcfp.com** or call **1-866-556-8298.**

Scan to learn more about your Accident Protection Plan.

Accident Protection

Help protect yourself from the unexpected cost of an accident

Round out your health plan benefits with the Accident Protection Plan, which helps cover added costs you may face following a covered accident. The plan covers more than 80 injuries and care services, from burns and concussions to ambulance rides and rehabilitation. If you or a covered family member is injured during your plan year, the Accident Protection Plan will pay you a cash benefit—and you can use the money any way you want.

How Accident Protection works—an example

Matt was playing in his softball league when he tore a knee ligament and broke a wrist. His Accident Protection coverage provided the following benefits.

Initial care/hospital care	Payment
Ambulance (ground)	$200
Emergency room visit	$100
Initial physician visit	$100
Total:	**$400**

Follow-up care/common injuries	Payment
Diagnostic MRI exam	$175
Wrist fracture treatment	$900
Surgical ligament tear repair	$400
Knee immobilizer	$150
Follow-up physician visit	$50
Physical therapy sessions (10 total)	$250
Organized sporting injury benefit	$481
Total:	**$2,406**

Total cash benefit paid to Matt

$2,806

See specific coverage details in the Benefits Summary section of this guide.

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For complete plan details, refer to the certificate of coverage.

Scan to learn more about your Critical Illness Protection Plan.

Critical Illness Protection

Get financial support during a serious illness

Experiencing a critical illness can be devastating to you, your family and your finances. The Critical Illness Protection Plan is designed to help ensure that should you or a covered family member be diagnosed with a covered critical illness — including heart attack, stroke and cancer — you'll get a cash payment to use any way you want.

In order to receive the Coronavirus benefit, you must be diagnosed by a physician, which includes a positive test, and be confined in the hospital for 20+ hours within 14 days of that diagnosis.

How Critical Illness Protection works—an example

Sharon was diagnosed with invasive cancer (cancer level I). Six months later, she had a stroke. Here's a look at Sharon's Critical Illness coverage benefits.

Coverage	Payout percentage	Payment
Invasive cancer (cancer level I)	100%	$20,000
Stroke	100%	$20,000
Total:		**$40,000**

See specific coverage details in the Benefits Summary section of this guide.

Total cash benefit paid to Sharon

$40,000

For complete plan details, refer to the certificate of coverage.

Critical Illness Protection

How the Coronavirus benefit works:

Example # 1

Barb is not feeling well and decides to get a test for Coronavirus. Unfortunately, she tests positive and is told to go home and quarantine until her symptoms subside. Because Barb has not been confined to the hospital for more than 20+ hours, the Coronavirus benefit **will not pay out.**

Example # 2

Barb is not feeling well and decides to get a test for Coronavirus. Unfortunately, she tests positive for Coronavirus and her health care provider has found her oxygen level is low. Barb requires inpatient hospitalization and is confined to the hospital for more than 20+ hours. Because Barb has been diagnosed by her physician and confined to the hospital for more than 20 hours within 14 days of her diagnosis, the $1,000 Coronavirus benefit **will pay out.**

Example # 3

Barb is not feeling well and decides to get a test for Coronavirus. Unfortunately, she tests positive for Coronavirus and her health care provider has found her oxygen level is low. Barb requires inpatient hospitalization and is in the hospital overnight for 18 hours. Even though Barb was diagnosed by her physician and hospitalized, she was **not eligible** for the $1,000 Coronavirus benefit because she was not confined for 20+ hours.

Scan to learn more about your Hospital Indemnity Plan.

Hospital Indemnity Protection

Help protect yourself from the high costs of hospital care

Even with health insurance, a hospital stay can mean big out-of-pocket costs. The Hospital Indemnity Protection Plan covers hospital admission, hospital confinement and intensive care unit confinement. You'll get a direct cash payment to use any way you choose — giving you extra financial help so you can focus on feeling better.

How Hospital Indemnity Protection works—an example

Clark suffered head and shoulder injuries in an accident and was taken by ambulance to the emergency room. Following an evaluation, Clark was admitted to the hospital for continued treatment of his injuries. Here is how his Hospital Indemnity coverage paid out over the plan year.

Hospital Indemnity Plan	Payment
Hospital admission (day 1)	$1,000
Hospital confinement (days 2–5)	$400
ICU confinement (days 2-5)	$400
Total:	**$1,800**

See specific coverage details in the Benefits Summary section of this guide.

Total cash benefit paid to Clark

$1,800

For complete plan details, refer to the certificate of coverage.

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Benefit summaries

For complete plan details, refer to the certificate of coverage.

Honda
Summary of Benefits

Accident Protection Plan

Scan to learn more about your Accident Protection Plan.

Effective date: 01/01/2023

Eligibility	All active, full-time associates working 33 hours or more, or part-time associates working 16-32 hours per week.	
Coverage	24 hours (on or off the job coverage)	
Portability	Included	
Benefits	**Option A**	**Option B**
Initial care		
Ground ambulance	$200	$300
Air ambulance	$1,200	$1,800
Emergency room treatment	$100	$150
Physician office/urgent care (per visit)	$100	$150
Hospital care		
Hospital admission	$1,000	$2,000
Hospital confinement	$100	$200
Hospital ICU confinement	$200	$400
Follow-up care		
Appliances benefit		
Wheelchair	$150	$225
Knee scooter	$150	$225
Knee immobilizer	$150	$225
Lumbar spine brace	$150	$225
Walking boot	$100	$150
Walker	$100	$150
Crutches	$100	$150
Leg brace	$100	$150
Cervical collar	$100	$150
Cane	$50	$75
Ankle brace	$50	$75
Ankle boot	$50	$75
Air cast	$50	$75
Follow-up physician visit	$50	$100
Major diagnostic exam	$175	$250
Minor diagnostic exam	$50	$75
Prosthetic		
One device	$500	$750
Two or more devices	$1,000	$1,500
Rehabilitation facility (per day/up to 30 days)	$100	$150
Rehabilitation therapy (per visit/up to 10 Visits)	$25	$30
Common injuries		
Abdominal/thoracic surgery		
Surgery to repair	$1,000	$1,500
Exploratory without repair	$100	$150

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For complete plan details, refer to the certificate of coverage.

Accident Protection Plan

Cranial surgery	$200	$300
Eye surgery		
Removal of foreign body	$100	$150
Surgical repair	$200	$300
Hernia surgery	$200	$300
Arthroscopic surgery	$200	$300
Non-specific surgery		
General anesthesia	$200	$300
Conscious sedation	$100	$150
Tendon/ligament/shoulder cartilage/ rotator cuff/knee cartilage surgery		
Surgery to repair 1	$400	$600
Surgery to repair more than 1	$800	$1,200
Exploratory without repair	$150	$200
Blood/plasma/platelets	$300	$400
Burns		
2nd degree (at least 36% of body surface)	$500	$750
3rd degree (9 to 34 sq. inches)	$1,000	$1,500
3rd degree (35 or more sq. inches)	$8,000	$12,000
	Skin graft = 25% of burn benefit	
Coma	$10,000	$15,000
Concussion	$150	$200
Lacerations		
Greater than 15 cm	$400	$600
5 cm - 15 cm	$200	$300
Less than 5 cm	$50	$75
Not requiring sutures	$30	$45
Paralysis		
Quadriplegia	$10,000	$15,000
Hemiplegia	$5,000	$7,500
Paraplegia	$5,000	$7,500
Ruptured/herniated disc	$400	$600
Emergency dental work		
Crown(s)	$200	$300
Extraction(s)	$100	$150
Medical supplies/over-the-counter (one time per plan year)	$10	$20
Family child daycare (per day up to 30 days)	$30	$45
Lodging (per day up to 30 days)	$150	$225
Transportation (for special treatment more than 100 miles away, maximum of 3 trips per accident)	$200	$300
Fractures	Open reduction / Closed reduction	
Skull (depressed, except bones of face or nose)	$4,500 / $2,250	$6,000 / $3,000
Sternum	$4,500 / $2,250	$6,000 / $3,000
Hip, thigh (femur)	$4,500 / $2,250	$6,000 / $3,000
Skull (simple, except bones of face or nose)	$2,500 / $1,250	$3,250 / $1,625
Leg (from top of tibia to ankle joint)	$2,500 / $1,250	$3,250 / $1,625
Pelvis (excluding coccyx)	$2,500 / $1,250	$3,250 / $1,625

For complete plan details, refer to the certificate of coverage.

Accident Protection Plan

Vertebrae (body of)	$2,500 / $1,250	$3,250 / $1,625
Sacral/sacrum	$900 / $450	$1,200 / $600
Face or nose (except teeth)	$900 / $450	$1,200 / $600
Upper arm (elbow to shoulder)	$900 / $450	$1,200 / $600
Upper jaw (except alveolar process)	$900 / $450	$1,200 / $600
Ankle	$900 / $450	$1,200 / $600
Foot (except toes)	$900 / $450	$1,200 / $600
Forearm, hand, wrist (except fingers)	$900 / $450	$1,200 / $600
Kneecap	$900 / $450	$1,200 / $600
Lower jaw (except alveolar process)	$900 / $450	$1,200 / $600
Shoulder blade or collarbone	$900 / $450	$1,200 / $600
Vertebral process	$900 / $450	$1,200 / $600
Coccyx	$700 / $350	$1,000 / $500
Finger or toe	$300 / $150	$450 / $225
	Chip fractures: 25% of amounts shown for closed reduction	
Dislocations	Open reduction / Closed reduction	
Hip	$4,500 / $2,250	$6,000 / $3,000
Elbow	$900 / $450	$1,350 / $675
Ankle	$1,500 / $750	$2,250 / $1,125
Collarbone (sternoclavicular)	$900 / $450	$1,350 / $675
Foot (except toes)	$1,500 / $750	$2,250 / $1,125
Hand	$900 / $450	$1,350 / $675
Kneecap (patella)	$2,250 / $1,125	$3,400 / $1,700
Lower jaw	$900 / $450	$1,350 / $675
Shoulder blade	$900 / $450	$1,350 / $675
Wrist	$900 / $450	$1,350 / $675
Collarbone (acromioclavicular separation)	$500 / $250	$750 / $375
Finger or toe	$500 / $250	$750 / $375
Organized sporting activity injury	Increases amounts payable under follow-up care and common injuries sections by 25%	
Additional benefits		
Wellness benefit rider	$50, employee and insured spouse	

For complete plan details, refer to the certificate of coverage.

Accident Protection Plan

Additional information

1. Air ambulance – Must occur within 72 hours of the covered accident
2. Emergency room treatment – The care received within 72 hours of the covered accident causing injury which requires treatment on an emergency basis
3. Physician office/urgent care (per visit) – The visit must occur within 60 days of the date of the covered accident. This benefit does not apply to care provided by a physician in an emergency room or to care provided by a physician in any other health care facility that does not include the physician's office or that is not an urgent care center.
4. Hospital admission benefit – The admission must begin within 30 days of the date of the covered accident
5. Hospital confinement benefit – The confinement must begin within 30 days of the date of the covered accident
6. Hospital ICU confinement – The confinement must begin within 30 days of the date of the covered accident. This benefit is payable for each day during a confinement in an intensive care unit up to a maximum of 30 days per plan year for you or your dependent. If a benefit is payable under both this benefit and the hospital confinement benefit for the same day, only this benefit will be paid.
7. Appliance benefit – The expense for the appliance must be incurred within 90 days of the date of the covered accident that caused the injury
8. Follow-up physician visit – The follow-up visit(s) must occur within 90 days of the date of the covered accident. This benefit is payable for up to 3 visits per covered accident for you or your dependent.
9. Major diagnostic exam – MRI, CT, PET, EEG, ImPACT, SPECT. The exam must be performed within 60 days of the date of the covered accident in which symptoms suggest an injury has occurred.
10. Minor diagnostic – X-ray or laboratory test. The exam must be performed within 60 days of the date of the covered accident in which symptoms suggest an injury has occurred.
11. Prosthetic means an artificial limb or eye. It does not include hearing aids, dental aids including false teeth, eye-glasses, artificial joints or cosmetic prostheses such as hair wigs.
12. The expense for the prosthesis must be incurred within 365 days of the date of the covered accident
13. Rehabilitation therapy – Rehabilitation therapy services are limited to physical therapy, occupational therapy and speech therapy
14. Rehabilitation facility – Must occur within 30 days after a hospital confinement that is covered under the hospital care benefit and within 90 days of the date of the covered accident
15. Arthroscopic surgery must be performed within 90 days of the date of the covered accident
16. Cranial surgery benefit – Must be performed within 90 days of the date of the covered accident
17. Eye surgery benefit – The surgery or removal is received from the physician within 90 days of the date of the covered accident. This benefit is not paid for examination with anesthesia which:
    1. Does not involve surgery for removal of a foreign object; or
    2. Involves only the moveable fold of skin and muscle that covers the eye (the eyelid).
18. Hernia surgery – Must be performed within 90 days of the date of the covered accident
19. Non-specific surgery benefit – The surgery must be performed within 180 days of the date of the covered accident
20. Tendon/ligament/shoulder cartilage/rotator cuff/knee cartilage surgery benefit –The applicable repair surgery must be performed within 180 days of the date of the covered accident. This benefit will not be paid concurrently with the fracture benefit or dislocation benefit.
21. Blood/plasma/platelets benefit – A transfusion; or the administration, cross matching, typing and processing of blood plasma or blood platelets. The transfusion must occur within 90 days of the date of the covered accident.
22. Burn benefit – Treatment must be received from a physician within 72 hours of the covered accident
23. Coma – We will pay the maximum benefit amount if injury is sustained due to a covered accident which results in a coma; and the coma begins while you or your dependent's insurance is in force; and is diagnosed by a physician as having commenced within 90 days of the date of the covered accident.
24. A coma diagnosis must be supported by: a Glasgow Coma Scale Score of 8 or below throughout the time period stated in the definition of coma; and an electroencephalogram (EEG)
25. The term "coma" will not include any medically induced coma
26. Concussion benefit – A physician must diagnose the concussion within 72 hours of the covered accident

Accident Protection Plan

Additional information

27. Dislocations – An injury must be sustained due to a covered accident that results in your or your dependent's dislocation of a complete separated joint; and for which a physician treats the dislocation/separated joint either: a. surgically or b. non surgically; within 90 days of the date of the covered accident
28. This benefit is payable up to 1 time per covered accident for you or your dependent. The total amount that we will pay under this benefit and under the fracture benefit for all dislocations and fractures sustained as the result of any 1 covered accident will be the lesser of:
    1. the total amount payable for all; or
    2. an amount that will not exceed 2 times the amount determined to be payable for the 1 dislocation or fracture that pays the largest benefit
29. Emergency dental work – An injury must be sustained due to a covered accident which causes damage to a sound natural tooth (or teeth) and a physician extracts or repairs the tooth by placement of a crown. The extraction or placement of a crown must be performed within 90 days of the date of the covered accident.
30. The total amount that we will pay for all teeth extracted due to any 1 covered accident will not exceed the maximum benefit per extraction for up to 1 extraction; and all teeth repaired by a crown as the result of any 1 covered accident will not exceed the maximum benefit stated in the schedule per crown for up to 1 crown. Benefit will not be paid for injury caused by biting or chewing.
31. Family child daycare benefit – We will pay the maximum benefit amount shown for this benefit in the schedule for each day that your dependent receives child care if: you sustain an injury due to a covered accident that results in your confinement to a hospital; and the confinement begins within 30 days of a covered accident which caused the injury. We will not pay this benefit for any day of child care that extends beyond a maximum payment period of 30 days. The child receiving child care does not need to be a dependent, but must:
    1. qualify as a child, as defined, except that such child must be under age 14; or
    2. qualify as an incapacitated child
32. Fracture – Fracture means a broken bone which can be seen by X-ray or other similar diagnostic imaging and is a result of a serious injury. Fracture does not include stress fractures, which are tiny cracks in a bone that can arise by the repetitive application of force or from normal use of a weakened bone. Benefits are not payable for stress fractures. We will pay the maximum benefit amount that applies as shown for this benefit in the schedule if you or your dependent sustain an injury due to a covered accident: which results in a fracture; and for which a physician treats the fracture, either surgically or non surgically, within 90 days of the date of the covered accident.
33. Laceration – We will pay the maximum benefit amount that applies if you or your dependent sustain an injury due to a covered accident which results in a laceration that is treated by a physician within 72 hours of a covered accident. Laceration not requiring stitches, staple, or glue.
34. Lodging benefit – We will pay the maximum benefit amount for each day of a companion's lodging if you or your dependent sustain an injury due to a covered accident and: due to an injury, requires a confinement that is more than 100 miles one-way from you or your dependent's principal residence; the confinement occurs within 90 days from the date of the covered accident; a person who is a companion accompanies you or your dependent and such companion incurs lodging expense for the day; the day coincides with a day the confinement is covered under the policy; and treatment is prescribed by a physician. This benefit is payable up to 30 days per covered accident for you or your dependent's companion. The lodging cannot be owned by the companion, you, or your immediate family.
35. Medical supplies benefit – We will pay the maximum benefit amount for you or your dependent's purchase of over-the-counter medical supplies for an injury due to a covered accident. The purchase of the over-the-counter medical supplies must be within 90 days of the date of the covered accident. This benefit is payable up to 1 time per plan year for you or your dependent. Medical supplies mean supplies used to alleviate or treat the injury due to a covered accident. These supplies cannot be cosmetic in nature or only beneficial to your general health.
36. Organized sporting activity – Must be a competition or practice for a competition for amateurs only. The competition must be governed by a set of written rules, supervised by an adult that has completed all training required by the organization, and overseen by a legal entity such as a public school system or sports association that is governed by a board of directors.

Accident Protection Plan

Additional information

37. Paralysis benefit – We will pay the maximum benefit amount if you or your dependent sustain an injury due to a covered accident which results in: hemiplegia: total and permanent paralysis of one upper and one lower limb on opposite sides of the body; paraplegia: total and permanent paralysis of both lower limbs; or quadriplegia: total and permanent paralysis of both upper and lower limbs. The paralysis must be confirmed by a physician; be based on documented evidence that the paralysis was caused by an injury due to a covered accident; and commence within 90 days of the date of the covered accident.
38. Ruptured/Herniated disc benefit – We will pay the maximum benefit amount if you or your dependent sustain an injury due to a covered accident that results in a ruptured or herniated disc of the spine that is a direct result of the covered accident; and for which treatment is received from a physician within 90 days of the date of the covered accident. This benefit is payable up to 3 times per covered accident for you or your dependent.
39. Skin grafts benefit – We will pay the maximum benefit amount if you or your dependent sustain an injury due to a covered accident: which results in a skin graft; and the skin graft is for a burn that is payable under the burn benefit. This benefit is payable up to 3 times per covered accident for you or your dependent.
40. Transportation benefit: We will pay the maximum benefit amount if: You or your dependent sustain an injury due to a covered accident; the injury requires special treatment; and the first trip to the special treatment occurs within 90 days of the date of the covered accident. This benefit is not payable for: transport by ambulance if the ground or air ambulance benefit is also payable; or any later transport if the initial transport to the special treatment occurred more than 90 days from the date of the covered accident. This benefit is payable up to 3 times per covered accident for you or your dependent.
41. Wellness benefit – We will pay the maximum benefit amount for up to 1 health screening test performed for each person insured under this benefit per plan year
42. Health screening test is defined as: Stress test on a bicycle or treadmill fasting blood glucose test blood test for triglycerides serum cholesterol test to determine level of HDL and LDL bone marrow testing breast ultrasound CA 15-3 (blood test for breast cancer) CA 125 (blood test for ovarian cancer) CEA (blood test for colon cancer) Chest X-ray Colonoscopy Flexible sigmoidoscopy Hemocult stool analysis Mammography Pap smear PSA (blood test for prostate cancer) Serum Protein Electrophoresis (blood test for myeloma) Thermography Virtual Colonoscopy
43. Open reduction – Surgically corrected
44. Closed reduction – Non-surgically corrected

Summary of Benefits

Accident Protection Plan

Important details

This Summary of Benefits sheet is an overview of the Accident Protection 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 Summary of Benefits 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.

Dependent children are covered to age 26.

Exclusions

The policy does not cover loss due to disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, participating in a riot or felony, war, drug use not prescribed by a physician, loss occurring while intoxicated or engaged in hazardous activities (including any kind of air diving/gliding/bungee jumping, off-road motor use or motor race, stunt driving or speed testing), travel in a private aircraft (or commercial except as a fare paying passenger on a flight with at least 15 seats), or engaging in semi-professional or professional sports. Injury on the job is only covered under the 24-hour option.*

Coverage continues, upon timely payment of premium, unless terminated because the person is no longer actively at work for the sponsoring employer, or no longer meets the specific eligibility requirements stated in the policy, or the policy terminates. The policy is renewable at the option of the company. See the policy for terms and periods related to continuation during approved leaves.*

* Some state variations may apply.

Exclusions and limitations

We will not pay a benefit for a loss contributed to or caused by:

1. Sickness, disease, bodily or mental infirmity, or medical or surgical treatment of these (except pyogenic infections through an accidental wound)
2. Suicide or any loss which is intentionally self-inflicted
3. Active participation in a riot
4. Commission of or attempt to commission a felony
5. An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military
6. Loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician
7. Driving or in physical control of a motor vehicle while intoxicated
8. Engaging in hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing and Russian roulette
9. Riding in or driving any motor-driven vehicle in a race, stunt show or speed test
10. Travel or flight in, or descent from any aircraft, except if employment duties require you to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on:
    a) a scheduled route
    b) a charter flight seating 15 or more people
11. Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received
12. Injury arising out of or in the course of any occupation or employment for pay or profit, or any injury or sickness for which you or your dependent are entitled to benefits under any workers' compensation law, employers' liability law, or similar law, unless this insurance is issued on a 24-hour basis
13. An accident that occurs outside of the United States

In addition to the exclusions shown above, no payment will be made for treatment received outside of the United States.

Summary of Benefits

Critical Illness

Scan to learn more about your Critical Illness Protection Plan.

Effective date: 01/01/2023

Eligibility	All active, full-time associates working 33 hours or more, or part-time associates working 16-32 hours per week.

Benefits payable	
Employee guarantee issue	$20,000
Spouse guarantee issue	$10,000
Child(ren) guarantee issue	$10,000
Portability	Included
Reoccurrence benefit	100% of benefit amount for base conditions payable per covered person or dependent for the same covered condition - 6 month separation
Additional occurence benefit	100% of the benefit amount payable per covered employee or dependent for a different covered condition - 30 day separation
Optional benefits	
Wellness benefit rider	$50 employee and insured spouse
Assumed enrollment	

Base + Partial benefits rider

Base covered conditions	% of maximum benefit amount payable per insured
Benign brain tumor	100%
Cancer - invasive	100%
Cancer - non-invasive	25%
Chronic renal failure	100%
Coma	100%
Coronary artery disease	25%
Heart attack	100%
Heart failure	100%
Major organ failure	100%
Permanent paralysis	100%
Ruptured aneurysm	100%
Stroke	100%
Additional covered conditions	
Coronavirus benefit - requires diagnosis by a physician, which includes a positive test and be confined in the hospital for 20+ hours within 14 days of diagnosis.	Flat $1,000 benefit
Partial benefits rider	
Addison's disease (adrenal hypo function)	25%
Amyotrophic lateral sclerosis (Lou Gehrig's Disease)	25%
Cerebrospinal meningitis (bacterial)	25%

For complete plan details, refer to the certificate of coverage.

Critical Illness

Partial benefits rider (continued)	
Cerebral palsy	25%
Cystic fibrosis	25%
Diphtheria	25%
Encephalitis	25%
Huntington's disease (Huntington's chorea)	25%
Legionnaire's disease	25%
Malaria	25%
Multiple sclerosis (definitive diagnosis)	25%
Muscular dystrophy	25%
Myasthenia gravis	25%
Necrotizing fasciitis	25%
Osteomyelitis	25%
Poliomyelitis	25%
Rabies	25%
Sickle cell anemia (excluding sickle cell trait)	25%
Systemic lupus erythematosus (SLE)	25%
Systemic sclerosis (scleroderma)	25%
Tetanus	25%
Tuberculosis	25%

Additional information

1. Benign brain tumor: a diagnosis of a non-malignant tumor in the brain, cranial nerves, or meninges: within the skull; and with a minimum size of 1 cm. The tumor must require: surgical or radiation treatment; or cause permanent irreversible neurological defects. Diagnosis of benign brain tumor must be: made by a physician who is a neurologist; and documented on an MRI of the brain or by pathological diagnosis. If the covered person or dependent is unable to undergo an MRI of the brain, the tumor must be documented by a CT scan of the head, with and without contrast. Benign brain tumor does not include any of the following: tumors of the skull; pituitary adenomas; germinomas.
2. Cancer: means a physician's diagnosis of cancer that is confirmed through the use of a medical test on a covered person's or dependent's blood or tissue. A diagnosis of cancer that is based only on symptoms will also be recognized if: there is medical evidence to support the diagnosis; and a physician is treating the covered person or dependent for cancer. No benefit will be payable for: melanomas except for melanomas that rise to the definition of level 1 cancer. Melanoma may begin in a tissue other than the skin, such as the eye or the intestines. Only skin cancer that is a level 1 cancer as defined above, is covered. No benefit is payable for any other skin cancer. pre-cancerous conditions. Some conditions are not cancer, but may be confused with cancer because they have some potential to become cancer in the future. For example, a polyp or small growth in the colon may be removed during a medical procedure to ensure that it does not develop into cancer. These kinds of conditions are not covered because they have not yet, and might not ever, become cancer. These conditions are not covered even when a medical procedure is advisable or performed to prevent the possibility of future cancer.
3. Level 1 cancer means: cancer cells have entered a phase of uncontrolled and aggressive growth beyond the primary site and have invaded other lymph nodes or organs and tissues, except that the following types are level 1 only at these stages: a. skin cancer, only if Breslow method staged at 1.0 mm maximum thickness or greater; papillary carcinoma of the thyroid, only if measured more than 1 cm in diameter; prostate cancer only if having a Gleason method stage at 7 or higher; papillary cancer of the bladder only if TNM method staged into a class greater than TaN0M0; or abnormal growth of white blood cells in the blood, bone marrow and lymphatic system, which includes lymph nodes, lymphatic vessels, tonsils, thymus, spleen, and digestive tract lymphoid tissue. Chronic lymphocytic leukemia that has progressed to at least Rai stage II or Binet stage b is considered level 1 cancer.

Critical Illness

Additional information

4. Level 2 cancer means: cancer cells are found only in their primary site which is the layer of cells in which they started; or cancer cells are limited to the same organ in which they started, and there is no medical evidence that the cancer has grown into a layer of tissue beyond the place where it started.
5. Chronic renal failure: the chronic irreversible failure to function of both kidneys of such severity that the physician recommends the covered person or dependent undergo hemodialysis or peritoneal dialysis at least weekly, or results in the covered person or dependent being placed on the United Network of Organ Sharing (UNOS) transplant list.
6. Coma: a condition diagnosed as: a continuous state of profound unconsciousness due to sickness; and with no reaction to external stimuli. Coma must: last for a period of 14 or more consecutive days; and require: significant medical intervention; and life support measures. Coma does not include: coma caused by: stroke; or a bodily injury resulting directly from an accident and independently of all other causes; medically induced coma; or a coma which results directly from drug or alcohol use.
7. Coronary artery disease: heart disease that: has been clinically diagnosed; and requires the covered person or dependent to undergo a surgical procedure. The procedure must be to open a blockage of one or more coronary arteries using: venous or arterial grafts (coronary artery bypass does not include placement of intravascular stent, laser relief or other like procedures); or balloon angioplasty, laser angioplasty, atherectomy or the placement of a stent to correct narrowing or blockage of one or more coronary arteries. Treatment must be recommended by a physician who is a cardiologist. If a physician who is a cardiologist has determined, in writing at the time the care is being given, that: the covered person or dependent requires one of the above procedures; but is too ill to undergo the procedure; the requirement that the procedure be recommended will be waived.
8. Heart attack (myocardial infarction): means the death of a portion of the heart muscle(myocardium) resulting from a blockage of one or more coronary arteries. Heart attack results in some permanent functional loss of heart contraction detectable by a regional contraction abnormality study on an imaging study. The diagnosis must include all of the following criteria concurrently: typical clinical symptoms such as central chest pain; acute diagnostic increase of specific cardiac markers; and new electrocardiographic changes of infarction.
9. Heart attack does not include any other disease or injury involving the cardiovascular system. Heart attacks that occur during a medical procedure are not included. Cardiac arrest not caused by a myocardial infarction is not a heart attack.
10. Heart failure: a physician's diagnosis of failure of the heart requiring the complete replacement of the covered person's or dependent's heart with the heart from a human donor. This must be evidenced by placement on a national transplant list such as UNOS, unless a suitable donor is found otherwise.
11. Heart failure also includes any combination heart and lung transplant. If the physician has determined, in writing at the time the care is being given, that: the covered person or dependent is too ill to undergo the replacement; but would otherwise meets the criteria for the need for the replacement; the replacement requirement is waived.
12. Major organ failure: a diagnosis of failure of the lung, pancreas or liver requiring the complete replacement of the organ with an organ from a human donor. This must be evidenced by placement on a national transplant list such as UNOS, unless a suitable donor is found otherwise. Major organ failure also includes disease of the bone marrow and which requires the replacement of the covered person's or dependent's bone marrow by allogeneic and/or umbilical cord blood transplant.
13. If the physician has determined, in writing at the time the care is being given, that: the covered person or dependent is too ill to undergo the replacement; but would otherwise meet the criteria for the need for the replacement; the replacement requirement is waived.
14. Major organ failure does not include any of the following: organs transplanted simultaneously with the heart; however, these may be covered under the definition of heart failure instead; bone marrow transplant that results from the treatment process for cancer; autologous bone marrow transplant (transplant in which the covered person's or dependent's own bone marrow is used).
15. Permanent paralysis: total and permanent loss of the use of 2 or more limbs (arms or legs or combination) due to sickness for a continuous period of at least 30 days.

Critical Illness

Additional information

16. Permanent paralysis does not include paralysis that: is due to or caused by stroke; or is due to or caused by a bodily injury resulting directly from an accident and independently of all other causes.
17. Ruptured aneurysm, ruptured cerebral, carotid or aortic aneurysm: a diagnosis by a physician of a ruptured cerebral, carotid or aortic aneurysm. The diagnosis must be supported by medical records. These records must include radiographically specific diagnostics such as, but not limited to: angiography; CT scan; MRI; or ultrasound.
18. Stroke: a cerebrovascular event resulting in measurable permanent neurological damage or impairment, including infarction of brain tissue, hemorrhage and embolism from an extra cranial source. The diagnosis must be based on objective clinical evidence of brain tissue damage for a continuous period of at least 30 days, using a current neuro imaging test such as: a CT Scan (computed tomography); MRI (magnetic resonance imaging); MRA (magnetic resonance angiography); PET Scan (positron emission tomography); or arteriography or angiography. Stroke does not include: transient ischemic attacks (TIA). A transient ischemic attack (TIA), also called a “mini stroke,” occurs when a blood clot blocks blood flow in the brain. The block is temporary (transient), and unlike an actual stroke, transient ischemic attacks do not generally kill brain tissue; or attacks of vertebrobasilar ischemia.
19. Reoccurrence benefit: we will pay a reoccurrence benefit equal to 100% of the maximum benefit amount if the covered person or dependent is: diagnosed with a second occurrence of a critical illness for which a benefit was previously paid; diagnosis is made 6 months or more following the initial diagnosis of the critical illness; and the covered person or dependent has not received treatment for the critical illness during this 6 month period. Maintenance medication or therapy is not considered to be treatment.
20. Only one reoccurrence benefit is payable for each critical illness per covered person or dependent. The reoccurrence benefit: does not apply to; and will not be payable for; an illness under the child critical illness category.
21. Coronavirus – The covered person or dependent must: be diagnosed by a physician with coronavirus, which includes a positive coronavirus test; and be confined within 14 days of that diagnosis for 1 or more consecutive days. Any pre-existing condition, limitation, or exclusion stated in the policy does not apply to this benefit. For the purposes of this benefit: confined means being an inpatient in a hospital. Coronavirus means COVID-19, SARS and MERS (including variant strains of COVID-19, SARS or MERS).
22. Wellness benefit – We will pay the amount shown on the schedule of benefits per plan year for any one of the following health screening tests performed on either the covered person or spouse provided the covered person elected coverage under the benefit. Health screening testis defined as: generally medically accepted cancer screening tests including, but not limited to: mammography; – CA 15-3 (blood test for breast cancer) CA 125 (blood test for ovarian cancer) CEA (blood test for colon cancer) an annual cervical cancer screening test which includes a conventional pap test, a human papillomavirus screening test that is approved by the Federal Food and Drug Administration, or the option of any cervical cancer screening test approved by the Federal Food and Drug Administration, PSA (blood test for prostate cancer), serum protein electrophoresis (blood test for myeloma), stress test on a bicycle or treadmill, fasting blood glucose test, blood test for triglycerides, serum cholesterol test to determine level of HDL and LDL, bone marrow testing, breast ultrasound, chest x-ray, colonoscopy, flexible sigmoidoscopy, hemocult stool analysis, thermography virtual colonoscopy. This benefit will be paid as long as the policy is in force and the covered person or spouse remains insured under this benefit of the policy. The benefit will be paid regardless of the results of the test. The wellness benefit is paid in addition to any other payments the covered person or spouse receives under the policy. Only one health screening test will be covered upon receipt by us of adequate documentation to support the performance of the test on the covered person or spouse.
23. Partial conditions limitation: we will not pay benefits for: a diagnosis of multiple sclerosis for clinically isolated syndrome (CIS); a diagnosis of systemic lupus erythematosus (SLE) for any form of lupus that is not diagnosed as systemic lupus erythematosus (SLE); a suspected or probable diagnosis of a listed condition. If a benefit becomes payable for rabies, it will be paid under the policy only once. If the policy includes a reoccurrence benefit, it will not apply to rabies.

Critical Illness

Important details

This Summary of Benefits sheet is an overview of the Critical Illness Plan 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 Summary of Benefits 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.

Dependent children are covered to age 26, end of month.

Exclusions

The policy does not cover loss due to suicide or intentionally self-inflicted injury, participating in a riot or felony, war, use of alcohol or the non-medical use of drugs, while on active duty in any armed forces except under the policy's Continuation During Leave of Absence provision, cosmetic or elective surgery, or any critical illness with a date of diagnosis prior to the effective date.*

Coverage continues, upon timely payment of premium, unless terminated because the person is no longer actively at work for the group or no longer meets the specific eligibility requirements stated in the policy; or benefits have been fully paid for qualifying conditions or the policy terminates. The policy is renewable at the option of the company. See the policy for terms and periods related to continuation during approved leaves.

* Some state variations may apply.

Exclusions and limitations

We will not cover a critical illness under the policy if it is due to:

1. An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature
2. Loss sustained while on active duty as a member of the armed forces of any nation (except during any time period coverage is extended under the Continuation During Leave of Absence provision)
3. Any loss which is intentionally self-inflicted
4. Active participation in a riot
5. The covered person's (or dependent's) commission of or attempt to commit a felony, or to which a contributing cause was the covered person's (or dependent's) engagement in an illegal occupation
6. Loss sustained or contracted in consequence of the covered person's (or dependent's) being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician
7. Attempted suicide, while sane or insane

Critical Illness

Exclusions and limitations

We also will not pay a benefit for a critical illness:

1. For which the covered person's date of diagnosis for any type of critical illness, as defined in the policy, was prior to his effective date of insurance
2. That was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a physician practicing within the United States or Canada

Cosmetic or elective surgery exclusion: We will not cover a critical illness under the policy if it is due to cosmetic surgery or elective surgery. Cosmetic surgery means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, cosmetic surgery does not mean reconstructive surgery performed to correct or repair abnormal structures of the body caused by:

1. Congenital defects
2. Developmental abnormalities
3. Trauma
4. Infection
5. Tumors
6. Disease; when intended to either improve function or create a normal appearance to the extent possible

Reconstructive surgery includes:

1. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures
2. Surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy

Elective surgery means:

1. Cosmetic surgery
2. Any other surgery that is:
   a. Not for the purpose of correcting or repairing abnormal structures of the body
   b. Not for the purpose of improving function
   c. If intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above

For purposes of excluding benefits, elective surgery does not include:

1. Caesarean section
2. Any surgery related to complications of pregnancy
3. Bariatric surgery performed in conjunction with a diagnosis of morbid obesity

Summary of Benefits

Hospital Indemnity

Scan to learn more about your Hospital Indemnity Plan.

Effective date: 01/01/2023

Hospital Indemnity Protection Plan (HIPP) — Voluntary

Legal entity	UnitedHealthcare insurance company	
Eligibility	All active, full-time associates working 33 hours or more, or part-time associates working 16-32 hours per week.	
Pre-existing conditions exclusion	None	
Portability	Included	
Telephonic claim submission	Included	
Base + enhanced plan benefits	**Option A**	**Option B**
Hospital admission (1 day/plan year)	$1,000	$2,000
Hospital confinement (up to 364 days/plan year)	$100	$200
ICU confinement (up to 364 days/plan year)	$100	$200
Inpatient drug and alcohol (up to 30 days/plan year)	$100	$200
Inpatient mental and nervous disorder (up to 30 days/plan year)	$100	$200

Additional information

1. Portability – included. Coverage continued under portability terminates at age 75.
2. Hospital admission benefit: We will pay the daily benefit amount shown for this benefit in the schedule for the first day a covered person or dependent is admitted and confined in a hospital as an inpatient as a result of an injury or sickness. This benefit is payable up to 1 day per plan year per covered person or dependent. This benefit is payable once per period of confinement in a hospital per covered person or dependent. We will pay the daily benefit amount for the hospital admission benefit. The hospital admission benefit is not payable for: a newborn child's routine nursing or routine well baby care during the initial confinement in a hospital; admissions to skilled nursing facilities and rehabilitation centers; treatment for mental and nervous disorders; treatment for drug and alcohol addictions; emergency room treatment, outpatient surgery or treatment, or a hospital stay of less than 20 hours in an observation unit; or when a charge for a hospital room and board is not made.
3. Daily hospital confinement benefit: we will pay the daily benefit amount shown for this benefit for each day that a covered person or dependent is confined in a hospital as a result of an injury or sickness. This benefit is payable for each day during a period of confinement in a hospital up to a maximum of 365 days per plan year per covered person or dependent. If the hospital admission benefit is also payable, this benefit pays for each day after the first day during a period of confinement in a hospital up to a maximum of 364 days. The daily hospital confinement benefit is not payable for: any day for which the hospital admission benefit is payable; a newborn child's routine nursing or routine well baby care during the initial confinement in a hospital; admissions to skilled nursing facilities and rehabilitation centers; treatment for mental and nervous disorders; treatment for drug and alcohol addictions; or when a charge for a hospital room and board is not made.
4. Daily intensive care unit confinement benefit: we will pay the daily benefit amount for this benefit for each day that a covered person or dependent is confined in an intensive care unit of a hospital as an inpatient, as a result of an injury or sickness.
5. We will pay the daily benefit amount for each day during a period of confinement in the intensive care unit up to a maximum of 365 days per plan year per covered person or dependent. If the hospital admission benefit is also payable, this benefit pays for each day after the first day during a period of confinement in a hospital up to a maximum of 364 days. The daily intensive care unit confinement benefit is not payable for: any day for which the intensive care unit admission benefit is payable; treatment for mental and nervous disorders; treatment for drug and alcohol addictions; or when a charge for intensive care unit room and board is not made.

HONDA

Hospital Indemnity

Additional information

6. Drug and alcohol treatment benefit (inpatient): We will pay the daily benefit amount shown for this benefit in the schedule for each day: a covered person or dependent is confined as an inpatient in a hospital; and receives treatment for drug and/or alcohol addictions. Treatment must be at the direction and under the care of a physician.
7. This benefit is payable up to 30 days per covered person or dependent per plan year. No benefitis payable after the covered person or dependent has met their lifetime limit of 300 days. For the purposes of this benefit, a place for the treatment of drug and/or alcohol addictions will be regarded as a hospital if: it is part of an institution that meets the requirements shown in the definition of hospital in this certificate; and it is listed in the American Hospital Association Guide as a general hospital. This benefit is not payable for the same day the daily hospital confinement benefit or mental and nervous disorder treatment benefit (inpatient) is paid.
8. Mental and nervous disorder treatment benefit (inpatient): We will pay the daily benefit amount for this benefit in the schedule for each day: a covered person or dependent is confined as an inpatient in a hospital; and receives treatment for mental and nervous disorders. Treatment must be at the direction and under the care of a physician.
9. This benefit is payable up to 30 days per covered person or dependent per plan year. No benefit is payable after the covered person or dependent has met their lifetime limit of 300 days. For the purposes of this benefit, a place for the treatment of mental and nervous disorder will be regarded as a hospital if: it is part of an institution that meets the requirements shown in the definition of hospital in this certificate; and it is listed in the American Hospital Association Guide as a general hospital. This benefit is not payable for the same day the daily hospital confinement benefit or drug and alcohol treatment benefit (inpatient) is paid.

Important details

This Summary of Benefits sheet is an overview of the Hospital Indemnity Plan 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 Summary of Benefits 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.

Dependent children are covered to age 26.

Exclusions

This certificate does not cover any loss caused by or resulting from (directly or indirectly):

1. An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature
2. Loss sustained while on active duty as a member of the armed forces of any nation (except during any time period coverage is extended under the Continuation During Leave of Absence provision)
3. Any loss which is intentionally self-inflicted
4. Active participation in a riot
5. Committing or attempting to commit a felony, or participating or attempting to participate in a felony

Exclusions

6. Loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician; this exclusion does not apply to the drug and alcohol treatment benefit (inpatient) if covered under this policy
7. Treatment received outside the United States or its territories
8. The reversal of a tubal ligation or vasectomy
9. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law
10. Participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a

licensed aircraft provided by a common carrier and operating between definitely established airports

11. A newborn child's routine nursing or routine well-baby care during the initial confinement in a hospital
12. Driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway
13. Mental and nervous disorders; this exclusion does not apply to the mental and nervous disorder treatment benefit (inpatient) if covered under this policy
14. Dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an injury or (b) correct a disorder of normal bodily function
15. Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received

Cosmetic or elective surgery exclusion: We will not cover any loss under the policy if it is due to cosmetic surgery or elective surgery.

Cosmetic surgery means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, cosmetic surgery does not mean reconstructive surgery performed to correct or repair abnormal structures of the body caused by:

1. Congenital defects
2. Developmental abnormalities
3. Trauma
4. Infection
5. Tumors
6. Disease; when intended to either improve function or create a normal appearance to the extent possible

Reconstructive surgery includes:

1. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures
2. Surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy

Elective surgery means:

1. Cosmetic surgery
2. Any other surgery that is
   a. Not for the purpose of correcting or repairing abnormal structures of the body
   b. Not for the purpose of improving function
   c. If intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above

For purposes of excluding benefits, elective surgery does not include:

1. Caesarean section
2. Any surgery related to complications of pregnancy or bariatric surgery performed in conjunction with a diagnosis of morbid obesity

Bi-weekly rates

For complete plan details, refer to the certificate of coverage.

Bi-weekly rates

Accident and Hospital Indemnity rates

Coverage is voluntary and must be elected. Bi-weekly rates are shown below:

Accident	Option A	Option B
Associate only	$2.22	$3.17
Associate + spouse	$3.51	$5.02
Associate + child(ren)	$4.13	$6.19
Family	$6.40	$9.54

Hospital Indemnity	Option A	Option B
Associate only	$3.19	$6.38
Associate + spouse	$7.90	$15.80
Associate + child(ren)	$7.01	$14.02
Family	$12.57	$25.14

For complete plan details, refer to the certificate of coverage.

Bi-weekly rates

Critical Illness rates

Coverage is voluntary and must be elected. Bi-weekly rates are shown below:

Associate $20,000 / Spouse $10,000 / Child(ren) $10,000				
Bi-weekly Premium / **Age range**	**Associate only**	**Associate + spouse**	**Associate + child(ren)**	**Family**
Under 25	$1.94	$2.86	$2.49	$3.42
25-29	$2.49	$3.74	$3.05	$4.29
30-34	$3.14	$4.71	$3.69	$5.26
35-39	$4.15	$6.28	$4.71	$6.83
40-44	$6.46	$9.55	$7.02	$10.11
45-49	$10.34	$14.95	$10.89	$15.51
50-54	$14.86	$21.09	$15.42	$21.65
55-59	$20.12	$28.20	$20.68	$28.75
60-64	$28.52	$39.92	$29.08	$40.48
65-69	$39.51	$54.69	$40.06	$55.25
70-74	$46.71	$68.63	$47.26	$69.18
75+	$52.43	$82.43	$52.98	$82.98

Handy tips to get started!

With UnitedHealthcare, you've got a helping hand. We offer plans that are designed to help you keep costs in check and enjoy a healthier life. Built for simplicity and speed, the supplemental health website offers self-service access to your claims — from any device.

Start by registering at **myuhcfp.com**

Click Member Log In. The first time you will need your Group ID #390051 and Group Name Honda. If you have questions, please call Customer Service at **1-866-556-8298.**

Round out your coverage with a supplemental health plan that's designed to help you plan for the unexpected

HONDA

For complete plan details, refer to the certificate of coverage.

If you are enrolled in the Honda UMR, UnitedHealthcare or BCBSAL medical plans, no action needed.

Actively working to get your benefit payout to you sooner

With a Benefit Assistant in your corner, the claims process is easier

If you're a UMR, UnitedHealthcare or BCBSAL medical member with a supplemental health plan—like Accident, Critical Illness or Hospital Indemnity—it's good to know you've got Benefit Assist looking out for you. The service, included at no additional cost, is designed to help make sure you get the benefits you're eligible for—and get them easier and faster. First, a Benefit Assistant will contact you if you may be eligible for a benefit payout. Next, they'll work with you to submit a claim on your behalf. **Here's how Benefit Assist does the heavy lifting for you:**

1. Reviewing

A Benefit Assistant will review your eligible medical claims

2. Supporting

If any of your medical claims may qualify for a benefit payout from your supplemental health plan, you will receive a call

3. Connecting

You'll be connected with a claims specialist who will help you submit a supplemental health plan claim on your behalf, so you can get your benefit eligible payout sooner

For complete plan details, refer to the certificate of coverage.

If you are not enrolled in the Honda UMR, UnitedHealthcare or BCBSAL medical plans, you can easily file a claim

Follow these steps if you have a UnitedHealthcare Accident, Critical Illness or Hospital Indemnity Plan.

Steps to file a claim:

Use the informational checklist below to gather the required information to start the claim process. Have this information ready when you call us. If someone makes the call for you, he or she will need to provide this information on your behalf.

Call us toll free at **1-866-556-8298.** Hours of operation are Monday–Friday, 8 a.m.–8 p.m. EST.

Information Checklist:

- ✔ Employer's name and location
- ✔ Your full name and Social Security number
- ✔ Your complete address and phone number
- ✔ Date of birth
- ✔ Marital status and number of dependents
- ✔ Last day you worked
- ✔ Details of medical event
- ✔ Physician's name, address and phone number
- ✔ Dates of treatment

After we've received all the completed paperwork, we will:

- ✔ Inform you by phone and letter within 5 business days that we are reviewing everything
- ✔ Ensure your claim receives a thorough, fair and objective evaluation
- ✔ Send benefit payment to you upon approval, if it applies. If your claim is not approved, a claim specialist will inform you by phone and letter

For complete plan details, refer to the certificate of coverage.

Here's the fine print

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Mail: UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

Online: UHC_Civil_Rights@uhc.com

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 member phone number listed on your ID card.

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, 1-800-537-7697** (TDD)

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

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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 русским (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

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.

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.

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 सेबाएं, निःशुल्क उपलब्ध है। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

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 shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

HONDA

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Specialty benefits and programs may not be available in all states or for all group sizes. Components subject to change.

United Healthcare Accident Protection product is provided by United Healthcare Insurance Company on form UHI-ACC-POL (2018) et al., in Texas on form UHI-ACC-POL-TX (2018) and in Virginia on form UHI-ACC-POL-VA (2018). The policies have exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. Some products are not available in all states. United Healthcare Insurance Company is located in Hartford, CT.

United Healthcare Critical Illness product is provided by United Healthcare Insurance Company on form UH ICI-POL-1 et al., in Texas on UH ICI-POL-1 and in Virginia on UH ICI-POL-1-V A. Critical Illness coverage is NOT considered minimum essential coverage under the Affordable Care Act and therefore does NOT satisfy the mandate to have health insurance coverage. Failure to have other health insurance coverage may be subject to a tax penalty. Please consult a tax advisor. The policies have exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. Some products are not available in all states. United Healthcare Insurance Company is located in Hartford, CT.

UnitedHealthcare Hospital Indemnity product is provided by UnitedHealthcare Insurance Company on policy forms UHIHIP-POL-TX, et al. and UHIHIP-CERT-TX, et al. in Texas and UHIHIP-POL-VA, et al. and UHIHIP-CERT-VA, et al. in Virginia. The product provides a limited benefit for certain hospital indemnity plan benefits. Please note: HOSPITAL INDEMNITY coverage is NOT considered minimum essential coverage under the Affordable Care Act and therefore does NOT satisfy the mandate to have health insurance coverage. Failure to have other health insurance coverage may be subject to a tax penalty. Please consult a tax advisor. The policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. This product is not available in all states. United Healthcare Insurance Company is located in Hartford, CT.

Benefit Assist support is available at no additional cost to groups with a health plan and supplemental health plan from UnitedHealthcare. Benefit payments associated with the Supplemental Health Plan Benefit Assist program are subject to eligibility requirements and benefits outlined in your UnitedHealthcare policy. For more details, contact your broker or UnitedHealthcare sales representative.