UnitedHealthcare®
A UnitedHealth Group Company

Choice Plus Plan AN - C Benefit Overview

Benefits	Network - Enrollee Pays	Non-Network - Enrollee Pays
Annual Deductible	$2,000 per Covered Person per calendar year, not to exceed $6,000 for all Covered Persons in a family.	$4,000 per Covered Person per calendar year, not to exceed $12,000 for all Covered Persons in a family.
Out-of-Pocket Maximum*	$2,000 per Covered Person per calendar year, not to exceed $6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. Copayments for some Covered Health Services will not apply to the Out-of-Pocket Maximum.	$8,000 per Covered Person per calendar year, not to exceed $16,000 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. Copayments for some Covered Health Services will not apply to the Out-of-Pocket Maximum.
Maximum Policy Benefit	$5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.	$5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.
Physician's Office Services	$25 per visit. No Copayment applies when a Physician charge is not assessed.	20% of Eligible Expenses. No Benefits for preventive care.
Maternity Services Prenatal, delivery, and postnatal physician care Inpatient Facility - (see hospital services)	Coverage is at the same level as Covered Health Services for any other Sickness or Injury. No Copayment applies to Physician office visits for prenatal care after the first visit.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury. *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Hospital - Inpatient Stay	0% of Eligible Expenses	*20% of Eligible Expenses
Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Therapeutic Treatments	0% of Eligible Expenses	20% of Eligible Expenses
Urgent Care Center Services	$75 per visit	20% of Eligible Expenses
Emergency Health Services	$125 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	$25 per visit	20% of Eligible Expenses Eye Examinations for refractive errors are not covered.
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	0% of Eligible Expenses	*20% of Eligible Expenses
Rehabilitation Services-Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	0% of Eligible Expenses	20% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	0% of Eligible Expenses	20% of Eligible Expenses
Injections Received in a Physician's Office	$25 per visit	20% per injection

* Prior notification is required for certain services.

Deductible does not apply to Emergency Health Services. Deductible applies for those services where a percentage of Eligible Expenses is applied, not for services with a flat dollar amount. Deductible applies toward Out-of-Pocket Maximum; per Covered Person. For Copayment Plans, you must meet the Deductible first, before Benefits are applied (excludes Emergency Room). *Only Deductibles and Copayments accumulate to Out-of-Pocket Maximum, Copays with a flat dollar amount do not apply.*

If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage prevails.

This overview is intended only to highlight Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage received upon enrollment in the plan.

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Pharmacy Plans

Product	H9	G4	S8	2V	K4
Tier 1*	$10	$10	$10	$10	$10
Tier 2*	$30	$30	$30	$35	$25
Tier 3*	$50	$50	$50	$60	$40
Mail Service *(90 day supply)*	2.5x	2.5x	2.5x	2.5x	2.5x
Deductible *(per covered person)*	$0	$100	$250	$0	$0
Maximum Out-of-Pocket *(per covered person)*	N/A	N/A	N/A	N/A	N/A

*The participant will pay the lesser of the applicable minimum copayment of the network pharmacy's Usual and Customary (U&C) charge.