UnitedHealthcare Choice Plus *Plan US-B*

As part of our commitment to keeping you in control of your health care decisions, our Choice Plus plan gives you the freedom to see any doctor in the UnitedHealthcare Choice network, including specialists, without a referral. You can even visit any out-of-network physician and still enjoy your benefits with somewhat higher deductibles and copayments.

With our Choice Plus plan, the vast majority of your health care needs are covered with little or no out-of-pocket costs when you visit a network doctor or facility. Plus, when you visit network doctors and hospitals, there aren't any claim forms or bills to worry about.

Some Important Benefits of Our Choice Plus Plan for Covered Services:

Visit any doctor in the Choice network in your area, including specialists, without designating a primary physician.

Visit any network hospital in your area.

You can choose to seek services outside our network, normally at a higher copayment and/or deductible.

Emergencies are covered anywhere in the world.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery, when covered health services are provided.

Prenatal care is included.

Routine check-ups are included.

Childhood immunizations are provided.

Mammograms are included.

Pap smears are included.

Vision and hearing screenings are covered.

Care Coordination[SM] services are available to help identify and prevent delays in care for those who might need specialized help.

United HealthCare Insurance Company
Local Addresses and Telephone Numbers

Austin	**Dallas**	**Houston**	**San Antonio**
1250 Capital of Texas Hwy. S. Building One, Suite 400 Austin, TX 78746 800-424-6480	5800 Granite Parkway Suite 900 Plano, TX 75024 800-458-5653	2000 West Loop South Suite 700 Houston, TX 77027 800-548-1078	8401 Datapoint Drive 6th Floor San Antonio, TX 78229 800-424-6480

Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network health care services under this benefit plan are covered only when provided, arranged, or authorized by a Network Physician. *Prior Notification is required for certain services received from non-Network providers.	**Annual Deductible:** $250 per Covered Person per calendar year, not to exceed $750 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $1,500 per Covered Person, per calendar year, not to exceed $3,000 for all Covered Persons in a family. The Out-of-Pocket Maximum includes the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.	**Annual Deductible:** $500 per Covered Person per calendar year, not to exceed $1,500 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $3,000 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 never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.
1. Ambulance Services - Emergency only	Ground Transportation: 20% of Eligible Expenses Air Transportation: 20% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*20% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $2,500 per calendar year.	20% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.	*40% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	$100 per visit *Notification is required if results in an Inpatient Stay.	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year.	$20 per visit	40% of Eligible Expenses
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	20% of Eligible Expenses	*40% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	20% of Eligible Expenses	*40% of Eligible Expenses
8. Hospital - Inpatient Stay	20% of Eligible Expenses	*40% of Eligible Expenses
9. Injections Received in a Physician's Office	$20 per visit	40% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services	20% of Eligible Expenses (except as covered under Physician Office Services).	40% of Eligible Expenses
12. Physician's Office Services	$20 per visit. No Copayment applies when a Physician charge is not assessed.	40% of Eligible Expenses

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13. Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	40% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $2,500 per calendar year.	20% of Eligible Expenses	40% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. 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.	20% of Eligible Expenses	40% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	20% of Eligible Expenses	*40% of Eligible Expenses
18. Transplantation Services	20% of Eligible Expenses	*40% of Eligible Expenses Benefits are limited to $30,000 per transplant.
19. Urgent Care Center Services	$50 per visit	40% of Eligible Expenses

Additional Benefits

Diabetes Treatment	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.
Mental Health and Substance Abuse Services – Outpatient Network and Non-Network Benefits are limited to 30 visits per calendar year.	*50% of Eligible Expenses	*50% of Eligible Expenses
Mental Health and Substance Abuse Services – Inpatient and Intermediate Network and Non-Network Benefits are limited to 30 days per calendar year.	*20% of Eligible Expenses	*40% of Eligible Expenses
Osteoporosis Detection and Prevention	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.
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.	20% of Eligible Expenses	40% of Eligible Expenses
Substance Abuse Services — Outpatient, Inpatient and Intermediate Network and Non-Network Benefits are limited to 3 Series of Treatments during the entire time a Covered Person is enrolled under the Policy.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.
Temporomandibular Joint Services	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.

Exclusions

Except as may be specifically provided in Section 1 of your Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments
Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; acupuncture; and other forms of Alternative Treatment.

B. Comfort or Convenience
Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, except that batteries for insulin pumps are covered for Covered Persons with diabetes as described in Section 1 of your COC, dehumidifiers and humidifiers; ergonomically correct chairs; non-Hospital beds and comfort beds; devices or computers to assist in communication and speech.

C. Dental
Except as specifically described as covered in Section 1 of your COC for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, services for a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs
Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications except as described for Covered Persons with diabetes in Section 1 of your COC. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services
Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care
Routine foot care (including the cutting or removal of corns and calluses). Diabetic foot care prescribed by a Physician is covered. Nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics except as described in Section 1 of your COC for Covered Persons with diabetes.

G. Medical Supplies and Appliances
Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, ostomy supplies, and gauze and dressings. Benefits for diabetic supplies are covered as described in Section 1 of your COC. Orthotic appliances that straighten or re-shape a body part (including some types of braces) except as described under Diabetes Treatment in Section 1 of the COC. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of your COC.

H. Mental Health
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Treatment of insomnia and other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis.

Treatment of Mental Illnesses which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as we determine, including, but not limited to, conduct and impulse control disorders; personality disorder; and paraphilias.

Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us. Residential treatment services.

I. Nutrition
Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups except as described under Diabetes Treatment in Section 1 of your COC. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance
Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Plastic surgery. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers
Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

L. Reproduction
Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan
Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Substance Abuse
Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us. Residential treatment services.

O. Transplants
Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of your COC. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

P. Travel
Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

Q. Vision and Hearing
Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

R. Other Exclusions
Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of your COC. Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations (other than immunizations for which Benefits are required by Texas law) or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. This exclusion does not apply to Medicaid or Tax Supported Mental Institutions.

In the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived. This exclusion does not apply to Medicaid or Tax Supported Mental Institutions. Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature. Surgical treatment and non-surgical treatment of obesity (including morbid obesity). Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Vein ligation/stripping. Reduction mammoplasty. Scar revision for keloids. Cranial banding.