

UnitedHealthcare
Choice Plus *Plan 063 Mod*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Choice Plus *Benefits Summary* PPO BASE (CORE)

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
<p>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.</p> <p>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.</p> <p>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.</p> <p>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.</p> <p>*Prior Notification is required for certain services.</p>	<p>Annual Deductible: \$500 per Covered Person per calendar year, not to exceed \$1,000 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$1,000 per Covered Person per calendar year, not to exceed \$2,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include 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.</p> <p>Maximum Policy Benefit: No Maximum Policy Benefit.</p>	<p>Annual Deductible: \$500 per Covered Person per calendar year, not to exceed \$1,000 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$2,500 per Covered Person per calendar year, not to exceed \$5,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include 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.</p> <p>Maximum Policy Benefit: \$1,000,000 per Covered Person.</p>
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	*40% of Eligible Expenses *Prior notification is required when the cost is more than \$1,000.
4. Emergency Health Services	\$100 per visit	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 from a Network Provider.	\$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		
Outpatient Surgery	20% of Eligible Expenses	40% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	40% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	20% of Eligible Expenses	40% of Eligible Expenses
Outpatient Therapeutic Treatments	20% of Eligible Expenses	40% of Eligible Expenses
12. Physician's Office Services	\$20 per visit. No Copayment applies when a Physician charge is not assessed. No Copayment for immunizations for children from birth to age five.	40% of Eligible Expenses No Copayment for immunizations for children from birth to age five.
13. Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	40% of Eligible Expenses

PPO BASE (CORE) **YOUR BENEFITS**

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year. This limit does not apply to breast prostheses.	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 per visit	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. Please note that this limitation does not apply to dose-intensive chemotherapy or bone marrow transplants.
19. Urgent Care Center Services	\$50 per visit	40% of Eligible Expenses

Additional Benefits

Chemical Dependency Services Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited as follows: up to 26 days for outpatient treatment in a nonresidential treatment program or partial- or full-day program services; up to 21 days for residential treatment program; and up to six days for detoxification in a medical or social setting per calendar year.	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Chiropractic Services Benefits for Chiropractic Services, other than the spinal services described under the Spinal Treatment section in the Missouri State Amendment, that are delivered by a licensed chiropractor acting within the scope of his or her practice.	\$20 per visit	40% of Eligible Expenses
Dental Anesthesia and Facility Charges	*Same as 8, 11, 12 and 13	*Same as 8, 11, 12 and 13
Hearing Screenings for Newborns	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Mental Health Services Must receive prior authorization through the Mental Health/Substance Abuse Designee for Benefits. (This requirement is waived for the first two outpatient sessions.) Outpatient Network and Non-Network Benefits include full or partial day treatment programs; Residential treatment is limited to 30 days per calendar year; and inpatient and intermediate services is limited to 90 days per calendar year.	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Osteoporosis Treatment	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
PKU Formula	20% of Eligible Expenses	40% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and one treatment per day. Network and Non-Network Benefits are limited to 26 visits per calendar year.	\$20 per visit	40% of Eligible Expenses