Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☐
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

Annual Out-of-Pocket Limit		
Individual	$3,500	$7,000
Family	$7,000	$14,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care *Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.* *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.*	No copay	20%*
Office Services - Sickness & Injury		
Primary Care Physician		
All other covered persons	$30 copay	20%*
Covered persons less than age 19 *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.*	No copay	20%*
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.*	$60 copay	20%*
Urgent Care *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.*	$100 copay	20%*

*After the Annual Medical Deductible has been met.
†Prior Authorization Required. Refer to DOC/BEN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Virtual Visits *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*	No copay	20%*
Emergency Care		
Accidental Dental	No copay*	No copay*
Emergency Ambulance	No copay*	No copay*
Emergency Room[1]	$350 copay	$350 copay
Non-Emergency Ambulance[1]	No copay*	20%*
Inpatient Care		
Congenital Heart Disease Surgeries[1]	No copay*	20%*
Hospital Inpatient Stays[1]	No copay*	20%*
Inpatient Habilitative Services[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.	
Skilled Nursing Facility & Inpatient Rehabilitation Facility Services[1] *Limited to 30 days per year in a Skilled Nursing Facility.* *Limited to 60 days per year in an Inpatient Rehabilitation Facility.*	No copay*	20%*
Outpatient Care		
Habilitative Services		
Manipulative treatment services	$30 copay	20%*
Other habilitative services *For outpatient therapies (physical therapy, occupational therapy, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services.*	$30 copay	20%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	No copay*	20%*
Lab Testing[1] *Limited to 18 Presumptive Drug Tests per year.* *Limited to 18 Definitive Drug Tests per year.*	No copay	20%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Major Diagnostic and Imaging[1]	No copay*	20%*
Physician Fees for Surgical and Medical Services	No copay*	20%*
Rehabilitation Services		
Manipulative treatment services	$30 copay	20%*
Other rehabilition services	$30 copay	20%*
Limited to 36 visits of cardiac rehabilitation therapy per year.		
Limited to 20 visits of cognitive rehabilitation therapy per year.		
Limited to 20 visits of occupational therapy per year.		
Limited to 30 visits of post-cochlear implant aural therapy per year.		
Limited to 20 visits of physical therapy per year.		
Limited to 20 visits of pulmonary rehabilitation therapy per year.		
Limited to 20 visits of speech therapy per year.		
Scopic Procedures	No copay*	20%*
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.		
Surgery[1]	No copay*	20%*
Therapeutic Treatments[1]	No copay*	20%*
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.		
X-ray and other Diagnostic Testing[1]	No copay	20%*
Supplies and Services		
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Diabetes Self-Management and Training[1]	The amount you pay is based on where the covered health care service is provided.	
Durable Medical Equipment, Orthotics and Supplies[1]	No copay*	20%*
Limited to a single purchase of a type of DME or orthotic every three years.		
Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.		
Enteral Nutrition	No copay*	20%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Hearing Aids *Limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement would apply to this limit in the same manner as a purchase.*	No copay*	20%*
Ostomy Supplies	No copay*	20%*
Pharmaceutical Products *This includes medications given at a doctor's office or in a covered person's home.*	No copay*	20%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every three years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*	No copay*	20%*
Urinary Catheters	No copay*	20%*
Pregnancy		
Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient[1]	No copay*	20%*
Outpatient and Transitional Care[1]	$30 copay	20%*
Partial Hospitalization and Transitional Care[1]	No copay*	20%*
Other Services		
Autism Spectrum Disorder Services[1]	The amount you pay is based on where the covered health care service is provided.	
Cellular or Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.	
Dental/Anesthesia Services – Hospital Ambulatory Surgery Services[1]	The amount you pay is based on where the covered health care service is provided.	
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care[1]	No copay*	20%*
Kidney Disease Treatment[1]	The amount you pay is based on where the covered health care service is provided.	
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Disorder Services[1]	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Transplantation Services *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	Not covered

*After the Annual Medical Deductible has been met.
Prior Authorization Required. Refer to 000/SBN.

Pharmacy Benefits

	In Network	Out of Network
Annual Pharmacy Deductible		
Individual	You do not have to pay a pharmacy deductible	
Family	You do not have to pay a pharmacy deductible	

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 $	$10	$10	$25
Tier 2 $$	$35	$35	$87.50
Tier 3 $$$	$70	$70	$175

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to **welcometouhc.com > Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to **welcometouhc.com > Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With **myuhc.com®**, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.

Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.