UnitedHealthcare

Choice Plus

Plan BC-B

Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Member Pays	Non-Network Benefits/ Member Pays^
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. United Healthcare of New England, Inc. is financially responsible for Network Benefits and UnitedHealthcare Insurance Company is financially responsible for Non-Network Benefits.	UnitedHealthcare of New England, Inc. is financially responsible for Network Benefits. **Annual Deductible:** $ 300 per Covered Person per calendar year, not to exceed $600 for all Covered Persons in a family. Annual Deductible does not apply to preventative care benefits, including immunizations, periodic health exams for adults and children, as well as those mammograms, cytological exams and diagnostic tests associated with periodic health exams; prenatal maternity care, well child care; including vision and auditory screening; voluntary family planning; nutrition counseling; and health education. **Out-of-Pocket Maximum:** No Out-of-Pocket Maximum **Maximum Policy Benefit:** No Maximum Policy Benefit.	United HealthCare Insurance Company is financially responsible for Non-Network Benefits. **Annual Deductible:** $ 350 per Covered Person per calendar year, not to exceed $700 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $4,000 per Covered Person per calendar year, not to exceed $8,000 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. **Maximum Policy Benefit:** No Maximum Policy Benefit.
1. Physician's Office Services	$15 Copay per visit. No copayment applies when a Physician charge is not assessed.	30% of Eligible Expenses after Deductible
2. Hospital - Inpatient Stay	No copayment after deductible	*30% of Eligible Expenses after Deductible
3. Emergency Health Services In an Emergency, you have the option to call 911. You will not be denied coverage for medical and transportation services incurred when Emergency Health Services are provided as a result of accessing services by calling 911.	$50 Copay per visit	Same as Network Benefit *Notification is required for an Inpatient Stay.
4. Urgent Care Centers	$25 Copay per visit	30% of Eligible Expenses after Deductible
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year.	$15 Copay per visit	30% of Eligible Expenses after Deductible
6. Injections Received in a Physician's Office	$15 Copay per visit	30% per injection after Deductible
7. Maternity Services	Same as 1, 2, 8, and 9 No copayment applies to Physician office visits for prenatal care after the first visit.	Same as 1, 2, 8, and 9 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
8. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	No copayment after deductible	30% of Eligible Expenses after Deductible
Outpatient Diagnostic Services	For lab and radiology/Xray: No copayment For mammography testing: No copayment	30% of Eligible Expenses after Deductible
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	No copayment after deductible	30% of Eligible Expenses after Deductible
Outpatient Therapeutic Treatments	No copayment after deductible	30% of Eligible Expenses after Deductible
9. Professional Fees for Sergical and Medical Services	No copayment after deductible	30% of Eligible Expenses after Deductible
10. 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 pulmonary rehabilitation per calendar year.(Does not apply to Home Health Care Benefits)	No copayment after deductible	30% of Eligible Expenses after Deductible

YOUR BENEFITS

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11. Speech, Hearing and Language Disorders Services	$15 Copay per visit. No copayment applies when a Physician charge is not assessed.	30% of Eligible Expenses after Deductible
12. Spinal Treatment (Chiropractic Care) Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network visits are limited to 24 visits per calendar year.	$15 Copay per visit	Non-Network Benefits are not available.
13.Mental Health Services – Outpatient** Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits for Mental Health Services to Treat conditions are limited to 24 visits per calendar Year. **This limit does not apply to treat conditions Described in ** below.**	*$15 Copay per visit.	*30% of Eligible Expenses after Deductible
14.Mental Health Services – Inpatient and Intermediate** Must receive prior authorization through the Mental Health/Substance Abuse Designee. For Inpatient Services, Network and Non-Network Benefits for Mental Health Services to treat conditions are limited to 60 days per calendar year. **This limit does not apply to treat conditions Described in ** below.**	No copayment after deductible	*30% of Eligible Expenses after Deductible.
15.Substance Abuse Services – Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per Calendar year but not less than $500 per calendar Year. The benefit limitation for Substance Abuse Does not apply when treatment for Substance Abuse is rendered in conjunction with treatment for Mental Illness.	*$15 Copay per visit	*30% of Eligible Expenses after Deductible
16.Substance Abuse Services – Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. For Inpatient Services, Network and Non-Network Benefits are limited to 30 days per calendar year. The benefit limitation for Substance Abuse does not apply when treatment for Substance Abuse is rendered in conjunction with treatment for Mental Illness.	No copayment after deductible	*30% of Eligible Expenses after Deductible.
17. Durable Medical Equipment Network and Non-Network Benefits are limited to a maximum benefit of $2,500 per calendar year.	No copayment after deductible	*30% of Eligible Expenses after Deductible *Prior notification is required when the cost is more than $1,000.
18. Prosthetic Devices Network and Non-Network Benefits are limited to a maximum benefit of $2,500 per calendar year.	No copayment after deductible	30% of Eligible Expenses after Deductible
19. Diabetes Equipment and Supplies Durable Medical Equipment for the treatment of diabetes is subject to the Durable Medical Equipment limit as described under *Durable Medical Equipment.*	No copayment for equipment and supplies. $15 Copay per visit for diabetes self-management education.	30% of Eligible Expenses after Deductible *Prior notification is required when the cost is more than $1,000.
20. Home Health Care	No copayment after deductible	*30% of Eligible Expenses after Deductible
21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 100 days per calendar year.	No copayment after deductible	*30% of Eligible Expenses after Deductible
22. Hospice Care	No copayment after deductible	*30% of Eligible Expenses after Deductible
23. Reconstructive Procedures	Same as 1, 2, 8, 9, and 18	*Same as 1, 2, 8, 9 and 18
24. Transplantation Services For Network benefits, Transplantation services must be received at a Designated Facility.	* No copayment after deductible	*30% of Eligible Expenses after Deductible

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25. Ambulance Services - Emergency only	Ground Transportation: No copayment after deductible Air Transportation: No copayment after deductible	Same as Network Benefit
26. Dental Services- Accident Only Benefits are available only for dental services started within 3 months and completed within 12 months of the accident.	*No copayment after deductible *Prior notification is required before follow up treatment begins.	*Same as Network Benefit *Prior notification is required before follow up treatment begins
27. Infertility Services	Same as 1, 2, 8, and 9	Same as 1, 2, 8, and 9
28.Medical Formulas Network and Non-Network benefits for food products Modified to be low protein for treatment of inherited Diseases of amino acids and organic acids are limited To $2,500 per calendar year.	No copayment after deductible	30% of Eligible Expenses after Deductible
29. Early Intervention Services Network and Non-Network Benefits are limited to $3,200 per calendar year. Network and Non-Network Benefits are limited to $9,600 during the entire period of time a Covered Person is covered under the Policy.	$15 Copay per visit	30% of Eligible Expenses after Deductible

**Benefits for the following conditions are paid at the same level as Benefits for any other condition, Sickness or Injury: Biologically-based Mental Disorders; rape-related mental or emotional disorders for victims of a rape or victims or an assault with intent to commit rape; Non-biologically-based Mental Illness of a Dependent who is a child under 19 years of age; Psychopharmacological services and neuropsychological assessment services for the diagnosis and treatment of either Biologically Based Mental Disorders or Mental Illness. For a list of Biologically-based Mental Disorders, please see Certificate of Coverage(Section 10: Glossary of Defined Terms) for the definition of the term “Biologically-based Mental Disorders.”

^Non-Network Benefits are based on a percentage of the provider’s fee up to a usual and customary charge.

Except as may be specifically provided in Section 1 of the 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, dehumidifiers and humidifiers; 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 teeth, jawbones or gums (including extractions, restoration, and replacement of teeth, medical or surgical treatment of dental conditions, and services to improve 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, 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 medication. 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 Unproved 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, Investigations or Unproved in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care. Examples include the following: cleaning and soaking the feet, applying skin creams in order to maintain skin tone, other services that are performed when there is not localized illness, Injury or system involving the foot. Treatment of flat feet or subluxation of the foot; shoe orthotics except as specifically described as covered in section 1 of the COC.

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, gauze and dressings, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services or supplies for the diagnosis or treatment of Mental Illness , alcohol or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee , are any of the following:

Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.

Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

Not consistent with the Mental Health/Substance Abuse Designee's level of care guidance or best practice as modified from time to time.

The mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

I. Nutrition

Except as specifically described as covered in section 1 of the COC, megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Except as specifically described as covered in section 1 of the 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. 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, except as described as covered in section 1 on your COC.

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 worker's compensation, no-fault automobile insurance, or similar legislation. If coverage under worker's 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 could have been covered under worker's 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. 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 the purpose of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Transplant service that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. 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.

P. Vision and Hearing

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

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations 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.

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.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecosmastia (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 a treatment for documented obstructive sleep apnea. Oral appliances for snoring.

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

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

R. Preexisting Conditions

Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

That date you have had Continuous Creditable Coverage for 6 months; or the date you have had Continuous Creditable Coverage for 6 months if you are a Late Enrollee. This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage prevails. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.