UnitedHealthcare®

Benefit Summary

Texas - Insurance Choice Plus
Premier - Plan AGZZ

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the UnitedHealthcare Tiered Benefit Plus Plan?

Get more protection with a national network and save with Tier 1 providers.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care from anyone in or out of our network, but you can save more money when you use the network. You can save even more when you use UnitedHealth Premium® Tier 1 providers.

> **Pay less by using UnitedHealth Premium Tier 1 providers.** They have been recognized for providing value.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$25	$1,000	20%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. 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.

UnitedHealthcare Insurance Company

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Congenital Heart Disease (CHD) Surgeries		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Accident Only		
	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.	20% co-insurance, after the network medical deductible has been met. Prior Authorization is required.
Developmental Delay Services		
Benefits are paid at the same level as Benefits for any other Covered Health Service, except that the Benefit limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to services for developmental delays.	The amount you pay is based on where the covered health service is provided.	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
Diabetes Self Management Items Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.	
		Prior Authorization is required for diabetes equipment in excess of $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Services and Serious Mental Health Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Osteoporosis Detection and Prevention		
	The amount you pay is based on where the covered health service is provided.	
Ostomy Supplies		
Limited to $2,500 per year.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Phenylketonuria and Other Heritable Diseases		
	The amount you pay is based on where the covered health service is provided.	

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Childhood Immunizations	You pay nothing. A medical deductible does not apply.	You pay nothing. A medical deductible does not apply.
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 co-pay, co-insurance or deductible.		
Prosthetic Devices for other than Arms and Legs		
Benefits for Prosthetic Devices for Artificial Arms and Legs can be found under Orthotic Devices and Prosthetic Devices - Artificial Arms and Legs.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
No coverage for cosmetic procedures, except for craniofacial abnormalities for children under age 18.	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits, services must be received at a designated facility. We will refer you to the Designated Facility most suitable, in our opinion, to treat your condition. In the event that the selected Designated Facility is located outside of Texas and you do not wish to travel outside the state, we shall refer you to an alternate Designated Facility within the State of Texas. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$75 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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.	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to prescription and non-prescription oral agents for controlling blood sugar levels. Note: If an Outpatient Prescription Drug Rider is included under the Policy, Benefits for the prescription and non-prescription oral agents will be provided under the Outpatient Prescription Drug Rider. Otherwise, the Benefits will be provided under the Certificate. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or 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 or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes. Shoe orthotics. This exclusion does not apply to podiatric appliances or therapeutic footwear as described under Diabetes Services or Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs in Section 1 of the COC. Shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC. Infant formula and donor breast milk. This exclusion does not apply to amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to:

- Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in Section 1 of the COC, which meet the definition of a Covered Health Service.
- Amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC.
- Formulas for phenylketonuria (PKU) or other heritable diseases.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Services your plan does not cover (Exclusions)

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

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 Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.