Plan Details: 2024

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MEMBER SERVICES FOR TRADITIONAL PLAN

Hours	8am-8pm all time zones
Phone Number	1-800-889-2535
Prospective Members Phone	1-800-889-2535
Web Address	www.myuhc.com

GROUP CONTRACT DETAIL

Carrier Name	United HealthCare
Group Contract Number	717292
Network Name	United Healthcare Choice Plus Network

Details on this page represent a summary for this plan. For further information, call the carrier directly at the number listed in Who to Contact.

Coverage Documents

Summary of Benefits and Coverage for 2023

Uniform Glossary of Health Coverage and Medical Terms

Summary of Benefits and Coverage for 2024

Uniform Glossary of Health Coverage and Medical Terms

Coverage Highlights

Medical Coinsurance/Copay/Deductibles/Benefit Maximum	
Office Visits - Preventive	100% coverage (SEE NOTE)
Office Visits - Diagnostic	$25 Primary Care Physician Copay (SEE NOTE)
Office Visits - Specialist	$50 Specialist Copay / $25 Tier One Provider Copay (SEE NOTE)
Annual Medical Deductible - Individual	$1000 (SEE NOTE)
Annual Medical Deductible - Family	$2000 (SEE NOTE)
Annual Out of Pocket Maximum - Individual	$3500 (SEE NOTE)
Annual Out of Pocket Maximum - Family	$7000 (SEE NOTE)
Lifetime Benefit Maximum	Unlimited

Note(s)

Office Visits - Preventive - In Network 100% Out of Network 60% subject to deductible

Office Visits - Diagnostic - In Network $25 Copay; Out of Network 60% subject to deductible

	Office Visits - Specialist - In Network $50 Copay; Out of Network 60% subject to deductible; $25 Copay if Tier One Orth, Neuro, Spine, Cardiac or Rheumatology class physician is used Annual Medical Deductible - Individual - In Network $1000 Out of Network $3000; Out of Network charges cross accumulate with In Network charges Annual Medical Deductible - Family - In Network $2000 Out of Network $6000; Out of Network charges cross accumulate with In Network charges Annual Out of Pocket Maximum - Individual - In Network $3500 Out of Network $7000; Out of Network charges cross accumulate with In Network charges Annual Out of Pocket Maximum - Family - In Network $7000 Out of Network $14000; Out of Network charges cross accumulate with In Network charges
Prescription Drugs	
Retail	Tier I $10 Tier II brand 25% with a $20 minimum and $100 maximum Tier III brand 50% with a $40 minimum and $150 maximum, subject to medical deductible
Mail / Home Delivery	Tier I $25 Tier II brand 25% with a $50 minimum and $250 maximum Tier III brand 50% with a $100 minimum and $375 maximum, subject to medical deductible. Tier IV Specialty - $250 Copay for 30 day supply, after annual deductible has been met (See Note) (SEE NOTE)
Annual Prescription Deductible - Individual	Generic Copays counts towards Medical OOPM; coinsurance counts toward deductible and out of pocket maximum
Annual Prescription Deductible - Family	Generic Copays counts towards Medical OOPM; coinsurance counts toward deductible and out of pocket maximum
Note(s)	Mail / Home Delivery - Mail Order prescriptions for Choice plans bypass deductible. Mail order preventive medication prescriptions for Choice Plus plans bypass deductible. Non-preventive mail order prescriptions for Choice Plus plans are subject to deductible.
Inpatient Services	
Inpatient Hospital Services	80% co-insurance/subject to deductible (SEE NOTE)
Allergy Testing NON HMO	80% co-insurance/subject to deductible (SEE NOTE)
Accupuncture NON HMO	80% co-insurance/subject to deductible (SEE NOTE)
Note(s)	Inpatient Hospital Services - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible Allergy Testing NON HMO - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible Accupuncture NON HMO - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Outpatient Services	
Emergency Room	$150 Copay then 80% co-insurance, deductible applies (SEE NOTE)
Outpatient Surgery	80% co-insurance (SEE NOTE)
Durable Medical Equipment	80% co-insurance (SEE NOTE)
X-ray and Lab Tests	80% co-insurance (SEE NOTE)
Maternity Care	80% co-insurance (SEE NOTE)
Home Health Care	80% co-insurance (SEE NOTE)
Physical Therapy NON HMO	$50 Copay (SEE NOTE)
Chemotherapy NON HMO	80% co-insurance (SEE NOTE)
Invitro Fertilization NON HMO	80% co-insurance/subject to deductible (SEE NOTE)

Note(s)

Emergency Room - In Network 80% co-insurance/subject to deductible, Out of Network 80% co-insurance/subject to deductible

Outpatient Surgery - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Durable Medical Equipment - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

X-ray and Lab Tests - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Maternity Care - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Home Health Care - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Physical Therapy NON HMO - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Chemotherapy NON HMO - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Invitro Fertilization NON HMO - In order to receive benefit coverage for infertility treatments, you are required to enroll in the Infertility Solutions Program prior to seeking services and to receive treatment at an designated Center of Excellence.

Mental Health / Substance Abuse	
Mental Health Inpatient	80% co-insurance/subject to deductible (SEE NOTE)
Mental Health Outpatient	80% co-insurance/subject to deductible (SEE NOTE)

Substance Abuse Inpatient	80% co-insurance/subject to deductible (SEE NOTE)
Substance Abuse Outpatient	80% co-insurance/subject to deductible (SEE NOTE)
Note(s)	Mental Health Inpatient - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible Mental Health Outpatient - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible Substance Abuse Inpatient - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible Substance Abuse Outpatient - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Other Services

Licensed Chiropractor	$50 Copay (SEE NOTE)
PCP Required	n/a
Anesthesia HMO	80% co-insurance/subject to deductible (SEE NOTE)
Note(s)	Licensed Chiropractor - Maximum 40 visits per year; Annual deductible must be fulfilled before co-insurance applies Anesthesia HMO - In Network 80% co-insurance/subject to deductible, Out of Network 60% co-insurance/subject to deductible

Coverage Information

Primary Care Physician (PCP)	n/a
PCP Required	n/a
PCP Referral Required to Visit Network Specialist	n/a
PCP Referral Required to Visit Network OB/GYN	n/a
Out of Area Coverage For Non-emergency Care	None
Artificial Insemination	Yes
Female Tubal Ligation	Yes
Male Vasectomy	Yes

Disease Management

Allergies
Asthma
Cancer
Congestive Heart Failure
Depression
Diabetes
Lung Conditions
Muscle or Joint Problems
Coronary Artery Disease
Prenatal Care
Rheumatoid Arthritis

NCQACORE

A summary of the benefits provided under the plan is contained in the Summary Plan Description. Full details are provided in the official plan document, which governs the operation of the plan. In the event that the content of this application or any oral representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document are controlling. Any specific questions regarding coverage information please refer to your Summary Plan Description (SPD) or the carrier.

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Questions? Find help in the Contact Directory.