

UnitedHealthcare Choice Plus *Plan 005*

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.

United HealthCare Insurance Company Local Addresses and Telephone Numbers

Austin
1250 Capital of Texas
Hwy. S.
Building One, Suite 400
Austin, TX 78746
800-424-6480

Dallas
5800 Granite Parkway
Suite 900
Plano, TX 75024
800-458-5653

Houston
2000 West Loop South
Suite 700
Houston, TX 77027
800-548-1078

San Antonio
5959 Northwest Parkway #117
San Antonio, TX 78249
800-424-6480

Choice Plus *Benefits Summary*

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.</p> <p>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: No Annual Deductible.</p> <p>Out-of-Pocket Maximum: No Out-of-Pocket Maximum.</p> <p>Maximum Policy Benefit: No Maximum Policy Benefit.</p>	<p>Annual Deductible: \$1,500 per Covered Person per calendar year, not to exceed \$3,000 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum: \$3,000 per Covered Person per calendar year, not to exceed \$6,000 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: No Copayment Air Transportation: 0% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*No Copayment *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.	No Copayment	*30% of Eligible Expenses *Prior notification is required when the cost is more than \$1,000.
4. Emergency Health Services	\$75 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.	\$15 per visit	30% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	No Copayment	*30% 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.	No Copayment	*30% of Eligible Expenses
8. Hospital - Inpatient Stay	No Copayment	*30% of Eligible Expenses
9. Injections Received in a Physician's Office	\$15 per visit	30% 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	No Copayment	30% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	30% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	No Copayment	30% of Eligible Expenses
Outpatient Therapeutic Treatments	No Copayment	30% of Eligible Expenses

YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
12. Physician's Office Services	\$15 per visit. No Copayment applies when a Physician charge is not assessed.	30% of Eligible Expenses
13. Professional Fees for Surgical and Medical Services	No Copayment	30% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.	No Copayment	30% 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.	\$15 per visit	30% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	No Copayment	*30% of Eligible Expenses
18. Transplantation Services	*No Copayment	*30% of Eligible Expenses Benefits are limited to \$30,000 per transplant.
19. Urgent Care Center Services	\$35 per visit	30% of Eligible Expenses
Additional Benefits		
Diabetes Treatment	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.
Mental Health Services – Outpatient Network and Non-Network Benefits are limited to 30 visits per calendar year.	\$15 per individual visit; \$10 per group visit.	30% of Eligible Expenses
Mental Health Services – Inpatient and Intermediate Network and Non-Network Benefits are limited to 30 days per calendar year.	No Copayment	30% of Eligible Expenses
Osteoporosis Detection and Prevention	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	\$15 per visit	30% of Eligible Expenses
Substance Abuse Services — Outpatient, Inpatient and Intermediate Network and Non-Network Benefits are limited to 3 Series of Treatments during the entire time a Covered Person is enrolled under the Policy.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.
Temporomandibular Joint Services	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.
Mental Health Services for Serious Mental Illness - Outpatient Network and Non-Network Benefits are limited to 60 visits per calendar year.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.
Mental Health Services for Serious Mental Illness - Inpatient Network and Non-Network Benefits are limited to 45 days per calendar year.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.	Coverage is at the same level as Covered Health Services for any other Sickness or Injury.

Exclusions

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; hypnosis; rolfing; massage therapy; aromatherapy; 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, except that batteries for insulin pumps are covered for Covered Persons with diabetes as described in Section 1 of your COC, dehumidifiers and humidifiers; ergonomically correct chairs; non-Hospital beds and comfort beds; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the 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 the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental 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, services for a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia, 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 medications except as described for Covered Persons with diabetes in Section 1 of your COC. 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 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, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses). Diabetic foot care prescribed by a Physician is covered. Nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics except as described in Section 1 of your COC for Covered Persons with diabetes.

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, ostomy supplies, and gauze and dressings. Benefits for diabetic supplies are covered as described in Section 1 of your COC. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces) except as described under Diabetes Treatment in Section 1 of the COC. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of your 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 that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of Mental Illnesses which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as we determine, including, but not limited to, conduct and impulse control disorders; personality disorder; and paraphilias.

Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us. Residential treatment services.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups except as described under Diabetes Treatment in Section 1 of your 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.)

United HealthCare Insurance Company

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.

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. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

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 workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' 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 would have been covered under workers' 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. Substance Abuse

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us. Residential treatment services.

O. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the 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 purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

P. 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.

Q. Vision and Hearing

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

R. 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 (other than immunizations for which Benefits are required by Texas law) 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. This exclusion does not apply to Medicaid or Tax Supported Mental Institutions.

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. This exclusion does not apply to Medicaid or Tax Supported Mental Institutions. Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature. Surgical treatment and non-surgical treatment of obesity (including morbid obesity). Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (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 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. Vein ligation/stripping. Reduction mammoplasty. Scar revision for keloids.

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.