Choice Plus Benefit Summary
Pennsylvania Judiciary

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period:	**Calendar Year**	
Deductible (per benefit period) **Individual** **Family**	None None	$250 $500
Plan Pays	100%	80% coinsurance after deductible (unless otherwise noted)
Out-of-Pocket Maximum (per benefit period) **Individual** **Family** *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.* *Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.*	$5,000 $10,000	$4,000 $8,000
Office / Virtual / Urgent Care Visits		
Primary Care Office Visits	100% after $10 copayment	80% after deductible
Specialist Office	100% after $10 copayment	80% after deductible
Virtual Visits	100%	Not Available
Urgent Care Center Visits	100% after $10 copayment	80% after deductible
Preventive Care		
Routine Adult		
Physical exams	100%	80% after deductible
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% after deductible
Mammograms	100%	80% after deductible
Routine Pediatric		
Physical exams	100%	80% after deductible
Pediatric immunizations	100%	80%; deductible does not apply
For more details on preventive care coverage, please visit www.uhc.com/preventivecare		
Hospital and Medical / Surgical Expenses		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $35 copayment (waived if admitted)	100% of charge after $35 copayment (waived if admitted)
Ambulance	100%	100%

Benefit	Network	Out-of-Network
Mental Health / Substance Abuse		
Inpatient Mental Health	100%	80% after deductible
Inpatient Detoxification / Rehabilitation	100%	80% after deductible
Outpatient Mental Health	100%	80% after deductible
Outpatient Substance Abuse	100%	80% after deductible
Rehabilitation Services – Outpatient Therapy		
Physical Therapy	100% after $10 copayment	80% after deductible
	60 visits/benefit period	
Manipulative Treatment	100% after $10 copayment	80% after deductible
	30 visits/benefit period	
Speech Therapy	100% after $10 copayment	80% after deductible
	20 visits/benefit period	
Occupational Therapy	100% after $10 copayment	80% after deductible
	20 visits/benefit period	
Cardiac Rehabilitation	100% after $10 copayment	80% after deductible
	100 visits/benefit period	
Pulmonary Therapy	100% after $10 copayment	80% after deductible
	20 visits/benefit period	
Post-Cochlear Implant Aural Therapy	100% after $10 copayment	80% after deductible
	30 visits/benefit period	
Cognitive Rehabilitation Therapy	100% after $10 copayment	80% after deductible
	20 visits/benefit period	
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury ($5,000 max per year; $1,500 max per tooth)	100%	100%
Diabetes Treatment	100% after $10 copayment	80% after deductible
Diabetic Supplies	100%	100% up to plan allowance
Major Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (X-ray, lab/pathology, allergy testing, etc.)	100%	80% after deductible
Durable Medical Equipment (DME) Limited to a single purchase of DME (including repair and replacement) every three years.	100%	80% after deductible
Hearing Aids	Limited to $3,000 every year. Benefits are further limited to a single purchase per hearing impaired ear every three years.	$50 deductible does not apply
Home Health Care	100%	80% after deductible
	200 visits/benefit period	
Hospice	100%	80% after deductible
Skilled Nursing Facility Care	100%	80% after deductible
	100 days/benefit period	
Transplant Services	100% In-network services only	
Oral Surgery	100%	80% after deductible
Precertification Requirements	Yes	

Important: UnitedHealthcare Insurance Company
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage. To view the COC, please log in to your member portal at www.myuhc.com.